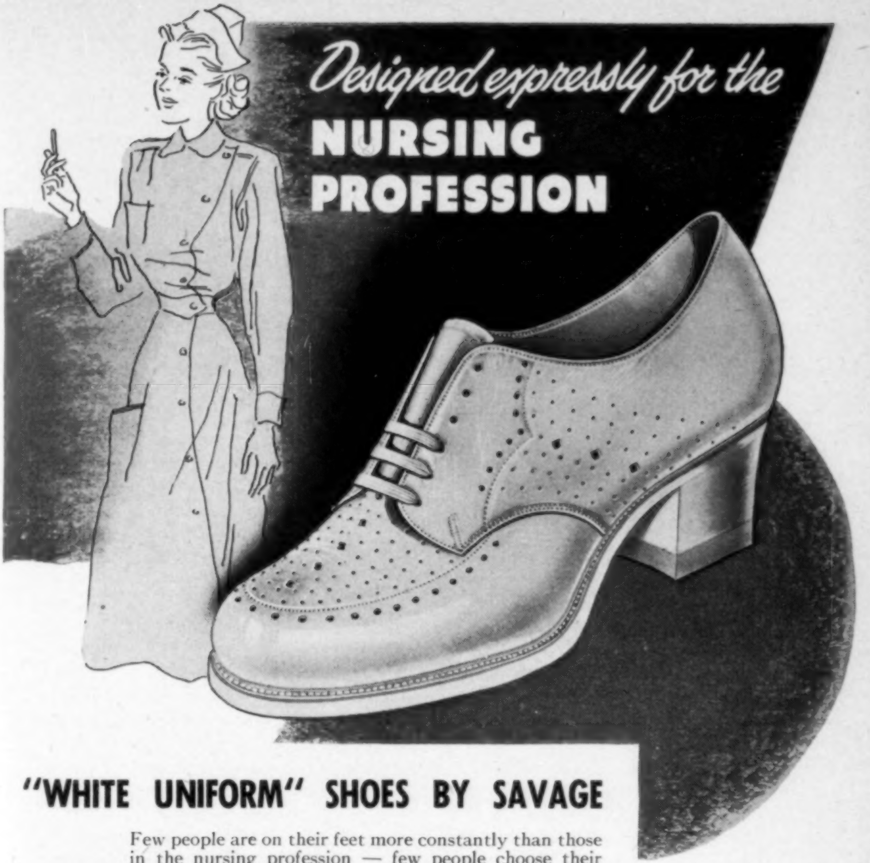

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Between Ourselves

Years ago we saw a painting depicting an artist's conception of Simon Fraser making the first descent of the river that bears his name. It was early in the nineteenth century that this memorable trip was taken against great odds. Not only was his frail craft menaced in that narrow canyon by a muddy torrent with whirling eddies and cruel rocks but he was in a strange country with hostile, suspicious bands of Indians as the only humans. He won through by doggedness of purpose, skill in manoeuvring his craft, and a spirit of friendliness.

Nursing is in a maelstrom not unlike the boat in the picture. The river of public demand for nursing service is running very high. The deadly rocks of criticism loom even higher. The whirlpools of conflicting opinions, both within and without the profession, make forward progress slow and treacherous. In many respects, the problem is even graver than that which faced Simon Fraser, for we have thousands of nurses each of whom has a responsibility for keeping the craft of nursing on an even keel and many of them are not pulling their weight. Perhaps part of the reason is because their share in the whole future of the nursing profession has not been made sufficiently clear to them. It is possible that the message that **Janet M. Geister** brings in this month's lead article will help to clarify their role.

* * *

Every nurse is familiar with the characteristic rhythm of "pain—food—relief," seen so commonly in patients with peptic ulcer. Treatment of an external ulcer consists very largely in putting the part at rest and avoiding any irritation. This simple procedure is impossible when the ulcer has a gastric site since the area is disturbed by muscular action each time food is taken and the normal hydrochloric acid secretion acts as a constant irritant. In time, fibrous scar tissue forms a protective layer. When the ulcer is small healing may occur, but when it is deep this is unlikely. **Dr. H. A. Stuart** describes the surgical therapy which may be used. **Margaret M. Flanagan** describes preparative and post-operative nursing care and **Grace MacLellan** outlines the history of a case where only diet therapy was used.

* * *

Quite a lot about various drugs this month. **Sister Ancilla** and **M. Wholey** give us the pharmacist's angle on the administration of some of the newer preparations. Then the whole problem of the measurement of doses is discussed on the Institutional Nursing pages. Toronto hospitals have swung over to the use of the metric system exclusively. **Dorothy Potts** tells us how they went about the change-over at the Toronto General Hospital. Because of the greater standardization the metric system of measurement provides it would seem a very sound practice if this method could be adopted in every hospital in Canada. The few months of complication while nurses were accustoming themselves to the new practice would be well repaid. We suggest you type out the list of equivalents which **Drs. Ferguson** and **Kerr** have included in their article and fasten it on the medicine cupboard door. Then when you pour a medication, think of the dosage in its metric units.

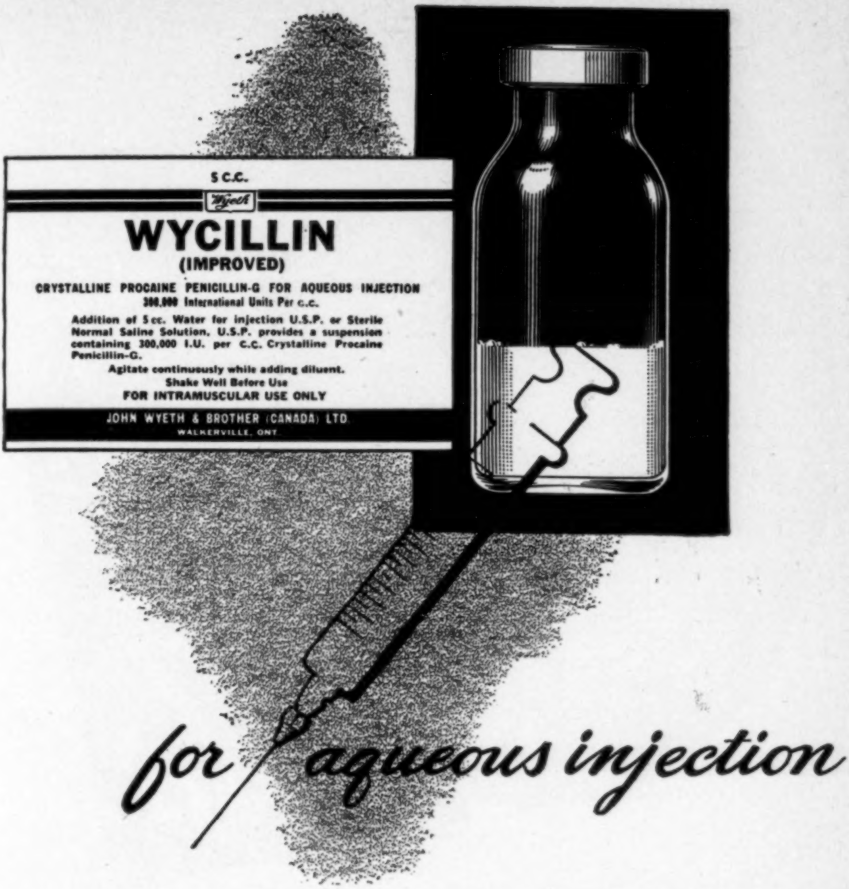
* * *

Immediately after the war we heard a great deal about rehabilitation. Latterly, we have thought of it less often. Yet it is an ever-recurrent problem with every patient who is admitted to hospital. **Dr. C. McG. Gardner** presents a very strong case in urging our consciousness of the need for more attention to rehabilitation.

* * *

The civil war in China has had its repercussion on the delivery of copies of the *Journal* to nurses in some of the areas. However, we are glad to say that the magazines that many of you are generously forwarding to Shanghai have apparently reached their destination safely. We have had a letter from Mrs. Bernice Chu Chen in which she says, in part: "Starting last week packages and packages of magazines coming into my office! It was simply wonderful! For all these, I want to thank you very much." So keep the "packages and packages" going.

Problems are a normal part of the process of living . . . Many who are maladjusted could have saved themselves present unhappiness had they tried to solve each problem as it arose, recognizing the fact that *some* which must be faced cannot be solved with complete satisfaction. — E. K. SPALDING, R.N., M.A. *in* "Professional Adjustments in Nursing."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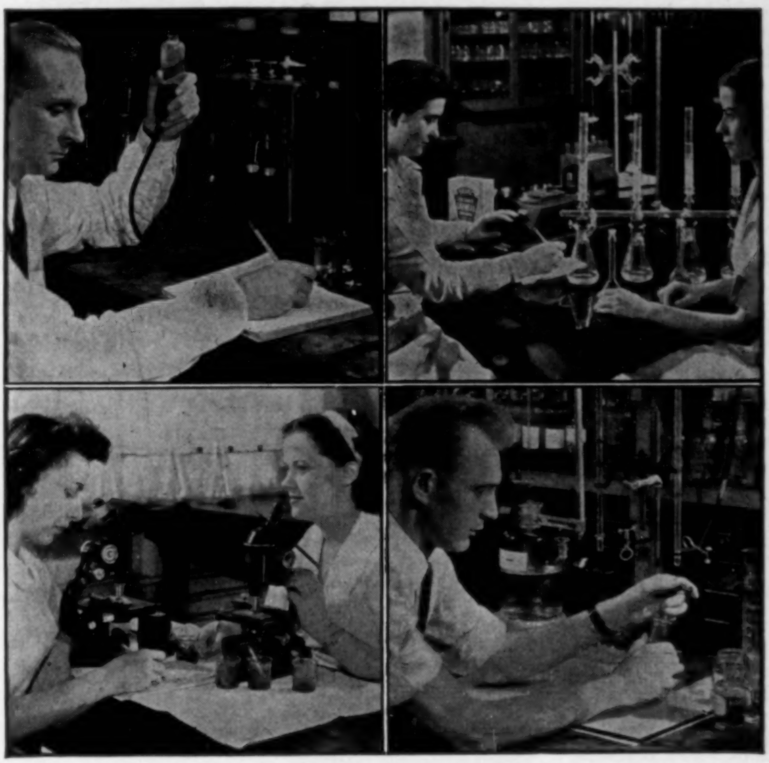

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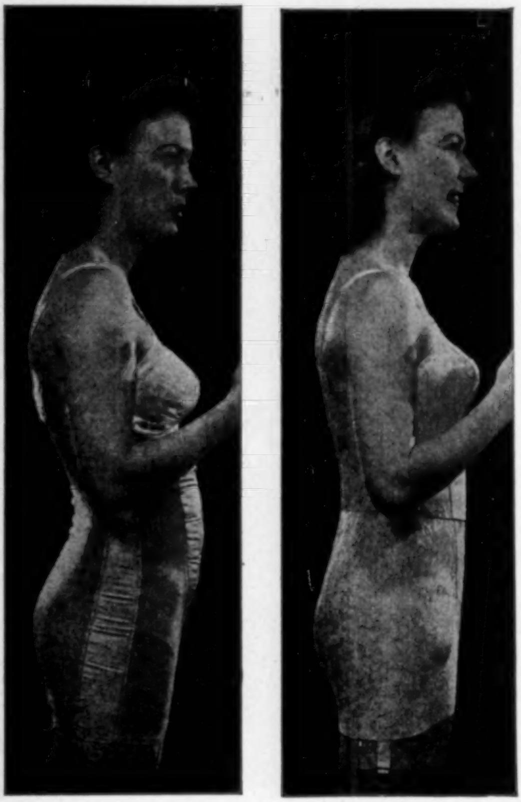

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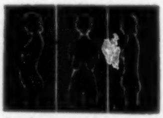

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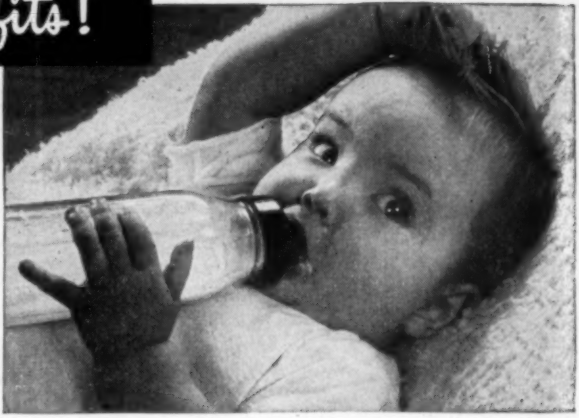

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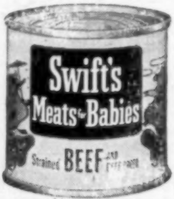

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FOR JUNIORS
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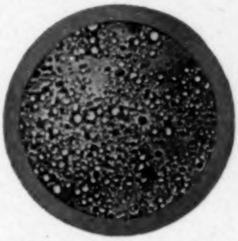

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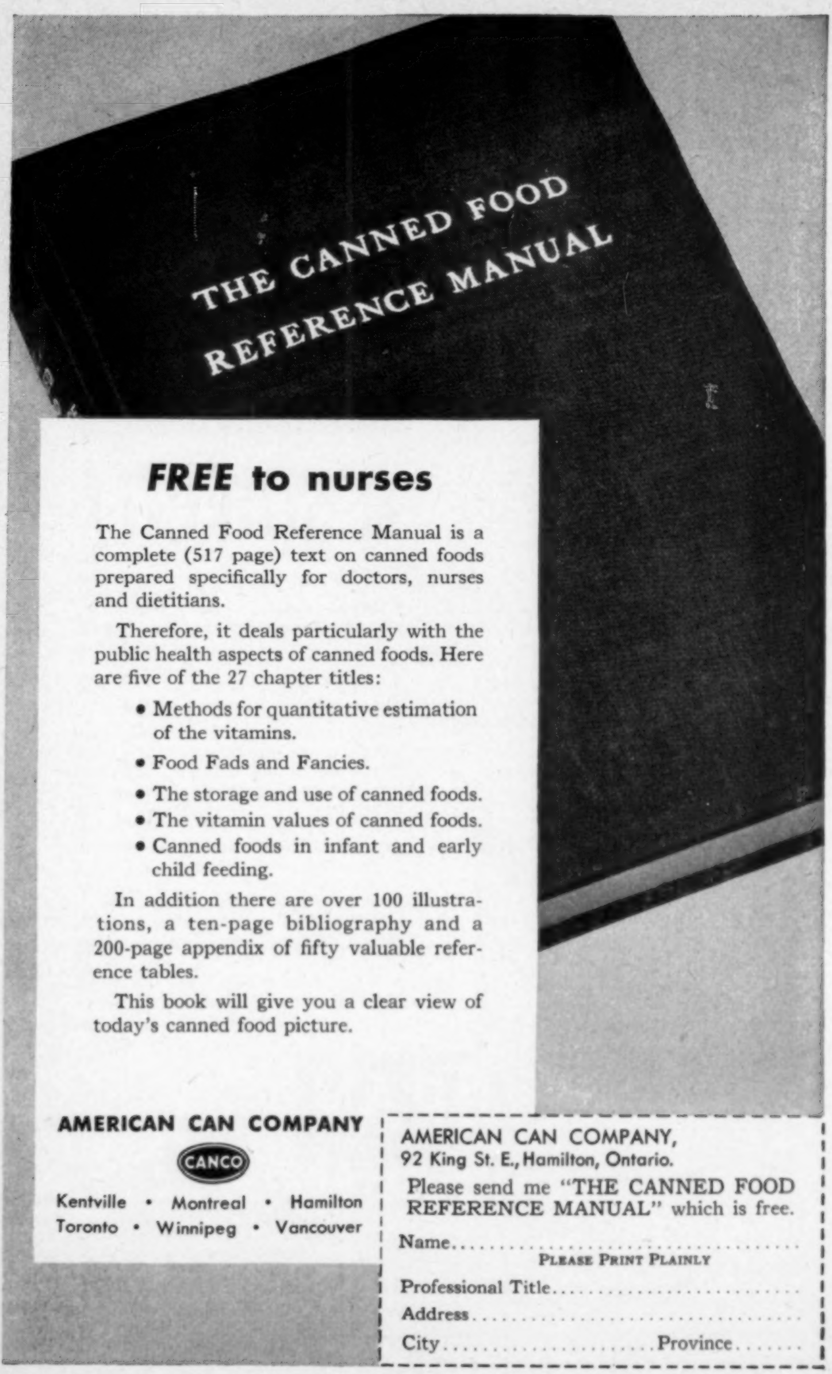

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CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-FIVE *NUMBER FIVE*

MONTREAL, MAY, 1949

Shedding the Halo

JANET M. GEISTER

Average reading time — 12 min. 6 sec.

IT TAKES courage to try to find answers to the major nursing problems that beset us today. Never has there been so much adverse comment on nurses and nursing. Complaints of shortages in quality and quantity come from all sources.

In the present so-called "crisis" there are no new major elements. We simply have here the cumulative results of conditions that have been developing for twenty-five years. They have been aggravated and sped to a climax by the pressures of war and the postwar health hunger, and the move in our society toward higher rewards for workers.

There is nothing wrong that cannot be remedied, if enough have the will to apply the remedies. Nursing is *of* the public and *for* the public. The doctor, hospital administrator, health authority, the patient, and general public have a direct interest in it; therefore the help of all is needed in attacking the problems of nursing.

The help that is primarily needed is not money or tears—though money is a part of the answer. Essentially we need new ideas. The old ideas of nursing education and the use of nurses are at the root of our present troubles. It is footless to chide the profession; nurses, as well as inadequately nursed patients, are victims of outworn ideas.

The immediate causes of shortages of hospital nurses are the increase in beds and unsatisfactory personnel practices. The immediate cause of half-empty nursing schools is the rejection of nursing as a career with suitable rewards. The basic causes, however, lie deeper.

We cannot separate quantity and quality shortages from their relationship to nursing education. The two areas are forged together. Nursing education has a dual function — that of providing nursing to hospital patients and that of educating for nursing. Hospitals instituted this dual

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Miss Geister will be well remembered by those who attended the C.N.A. convention in Sackville last year. She is first vice-president of the American Nurses' Association and chairman of the Advisory Board of the American Association of Industrial Nurses.

system in the 1870's as a public service. As its economic advantages became apparent, however, the motive changed.

Though the system was satisfactory in earlier days, by 1922 we were warned by the Rockefeller Committee on Nursing that it was unsound and would lead to serious trouble. Ten years later the Committee on the Grading of Nursing Schools of the American Nurses' Association repeated the warning. Yet today 90 per cent of our schools of nursing remain subject to hospital economics.

The advances of medical science and the great patient surge to hospitals have placed heavy new burdens on the student nurse. More patients to do more things for — more things to learn! Doctors add one new procedure after another in their diagnostic and treatment methods, and each doctor must have things done his own way. New medical procedures must be followed by new nursing techniques and the nurse must know enough to carry out orders intelligently. We cannot entrust human life to an automaton. The 1949 nursing curriculum can no more be a 1925 model than can that of any other living group.

It is idle to cry that we have "over-educated nurses." There are no such things. There are some *wrongly* educated nurses — and small wonder! The struggle between ward and classroom has become exceedingly grim. The student with one eye on the clock for class time and the other on the order book has little chance to learn the hundred little knowledges that make up the art of nursing.

The results of the dual load on students are evident. Of the number who entered training in Canadian schools in 1945, 20 per cent withdrew before graduation in 1948, and not all for matrimony. This high record of failure retards enrolments. And seasoned nursing administrators tell me that much of the complaint for inadequate nursing centres on graduates of recent years. The assembly-line form of nursing education forced on us by the war was good for neither nurse nor patient.

Both the Rockefeller and Grading Committees warned against the pernicious and wide practice of employing graduate staff nurses merely to supplement the services of students. It places the student in competition with the graduate, a first source of the deep resentments that later factored in the revolt from hospital work. This practice has delayed far too long the development of graduate staff nursing as a dignified, permanent, and substantial form of nursing. To it can be attributed some of the shortages that followed both World Wars. Hospital staff nursing still remains too much a no-man's-land, a blind alley.

The immediate causes of hospital nurse shortages are the greatly increased demand for nursing and the flight of nurses to other fields. Hospital bed occupancy in the U.S. increased 100 per cent in fifteen years — the nurse population but 13 per cent. Other fields are competing vigorously for quality nurses — industry, public health, the veterans' hospitals, doctors' offices, clinics.

Nurses were already turning away from hospital practice when the war sharply accelerated the movement. With many other jobs available, old resentments came to the surface. Inadequate pay was a handy limb on which to drape their grievances, but twenty-five other specific dissatisfactions with hospital duty are listed in the U.S. Bureau of Labor Statistics study. While 46 per cent were unhappy over the pay rates, 55 per cent, the highest number, complained of the lack of retirement and employment security. These things represent an urgent need.

By the time conditions began to improve, it was the old story of "too little — too late." The changes were not basic enough and nurses who had found useful employment elsewhere preferred to remain elsewhere. Too often the nurses drifting into the hospitals are those who cannot find employment elsewhere. Then the many splendid nurses, who have carried the nursing load through the hard years, must work doubly hard to offset the indifferent, and sometimes wretched, nursing.

The market is still a seller's market. The good nurse who feels needed digs in even harder. The poor nurse, feeling indispensable, uses the moment for her personal advantage. She does the least, expects the most, and cries to Heaven over the injustices!

Hospital nursing should be our most attractive field. There is no good reason why it cannot be. The public must face the fact that nursing will cost more than it has. Good nursing, like good anything else, has to be paid for. The halo, too long offered as part pay, is a poor substitute for the hard cash the landlord wants. Nurses are reasonable in their requests. They want only to live as decently as other workers do — they do not want the alumnae to support them when their legs give out.

Money alone, however, won't bring back the large numbers of quality nurses needed. Most of the complaints listed in the Bureau of Labor study, other than those related to pay and retirement, deal with administrative practices. There isn't one, in my opinion, that cannot be treated by some massive doses of the Golden Rule and common sense.

We humans criticize the things we don't understand. Few nurses can know the troubles that bedevil the administration, and few administrators know the troubles that bedevil the nurses. Both sides have their grievances. Patients need care nights and Sundays as well as in the hours nurses like best. Nurses want conditions that permit good nursing. Quality nurses hate hit-and-run work. They want something done about promotions, educational opportunities, avenues for settling grievances. The blind alley can and should become a main highway.

Money alone, I repeat, won't settle these matters. Only better pay *and bringing nurses into partnership* will. Nurses have always had to obey the rules; why not let them help make the rules? They can be trusted. Recovery can come only from the free interchange of opinions and ideas and subsequent compromise; from a 1949 concept of the principles of human relations. It cannot be achieved along the old lines of military discipline. We can no longer expect good nurses to be thinking people in relation to patient care and robots about everything else.

Another major need relates to supervision. The stress of recent years broke down much of our good supervision, yet supervision is the very backbone of good nursing. Without it, inevitably the patient suffers. The doctor goes away; the family goes away; the floor manager must take the place of both in protecting the patient's interests. She is a fourway transmitter between doctor, patient, management, and staff. If she stays unwrinkled and untroubled at her desk, then Heaven help the patient.

A good supervisor can strengthen weak nurses; a poor one can confound the best efforts of good ones. Six good nurses under a good supervisor can make circles around twelve mediocre ones under a weak supervisor. The best dollar investments of the hospital, in my opinion, are those put into quality supervision.

A number of causes brought the practical nurse on to the scene. The better use of professional nurses is one. Scarcities in personnel and the great increase in the chronic population are others. She is here to stay — the latest helper on the doctor's expanding team. Many nurses, however, do not understand the *why* of her coming and resentment remains high. It is not surprising. Nursing leaders took little trouble to help nurses understand the reasons for her presence. Abruptly she was thrust upon us and a profession, long trained to protect nursing standards, was told to support schools and legislation promoting her use. Inequalities in pay and privileges have angered the professional nurses. These things must be leveled off before there can be peace.

Some poorly prepared practical nurses have assumed prerogatives and authorities that have shocked the graduates. This is not true, of course, of the well-trained practical, but she is still scarce. The lines of demarcation between the two realms are still not clear. One reason is that, through custom, many tasks that are hospital service and not strictly nursing have been a part of the graduate's job. Time, test, and patience are needed to get the lines straightened.

No situation in hospital practice calls more for intelligent handling. It is a mistake in any realm to go ahead of public opinion. The co-operation of staff and private duty nurses is essential to the successful use of the practical nurse. It can be gained only through understanding and a share in policy making, not through orders. I have an infinite faith that the average nurse, once fully informed, can be trusted to co-operate for the good of the whole.

A more economical and efficient use of nursing calls for the co-operation of everyone concerned. The doctor can help in many ways. When nurses inadvertently or carelessly confuse the practice of nursing with that of medicine, the doctor can help them understand where the line is. It moves as medical science advances. Some of yesterday's practice of medicine are today's practice of nursing. During the war some medical tasks were assigned to nurses. The line has since been blurred. Good nurses do not want it that way. They want to practice only good nursing. On the nursing school committee the doctor can help greatly in modifying or strengthening the curriculum, according to the demands made on nurses.

The administrator can save many miles of travel by readjusting traffic lanes and the physical set-up. It is sheer waste for a nurse to walk a half-block to sterilize a needle, and even farther for ice cubes. Hospital architects, charmed with their long vistas, ought to consider the help's feet more.

Hospital boards, whose contact with hospital realities is too often only the oak-panelled directors' room and the auditor's statement, have a responsibility for being better informed. The board president who said the eight-hour day "had dimmed the light of Florence Nightingale's lamp" might well do eight hours duty some Sunday when the rain spoils his golf.

This matter of getting patients adequately nursed can be settled through the study and help of everyone concerned with patient care. More nurses are needed but, beyond that, new ideas are needed. Changes in nursing school control must come slowly. Changes in the use of nurses can come more rapidly. But old fears, prejudices, and ideas reaching into the past must be cast off. The central new idea is simply the old one of teamwork — a co-operation built on a democratic interchange of viewpoints and purposes.

Nurses need more money but, above all, they need to be brought into the partnership.

Coming Events

The *Canadian Dietetic Association* is holding its annual convention **June 15-17** at the Fort Garry Hotel, Winnipeg, Manitoba. A program has been planned which will include group conferences pertaining to the many phases of food work, interesting exhibits of food and equipment, and papers by outstanding guest speakers and members.

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The *Canadian Society of Radiological Technicians* will hold its seventh annual convention at Halifax, N.S., **July 3-5.**

The annual meeting of the *Saskatchewan Registered Nurses' Association* is scheduled for **May 26-27** at the Hotel Saskatchewan, Regina.

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The *Association of Nurses of the Province of Quebec* will meet for their annual convention in Montreal on **May 30-31.**

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The annual meeting of the *Registered Nurses' Association of Nova Scotia* will be held **June 8-10** at Baddeck.

Peptic Ulcer

H. A. STUART, M.D.

Average reading time — 9 min. 48 sec.

ETIOLOGY

PRESENT concepts of the etiology of peptic ulcer lean heavily on the psychogenic factor. For many years a more than casual connection between dyspepsia and disturbances of the psyche has been noted. The increasing tempo of Western civilization, due to industrialization, its concomitant frustration and economic insecurity, leaves an ever-increasing number of scars on the first portion of the duodenum. These bear not too silent witness of the composite structure of man.

The basic facts of the psychomatic mechanism in digestion were evolved by Pavlov whose monumental investigations on conditioned reflexes in dogs indicated that digestion was not a mere vegetative process. By his experiments he showed that the control of the sensorium over qualitative and quantitative variations in the gastric juices could be accentuated by conditioned education. Much of the clinical significance of his observations was overlooked for some years. A powerful impetus to the validation of a psychomatic pattern in the gastric function of man resulted from the factual clinical observations of Harvey Cushing. In 1931 he presented his observations in the Balfour Lecture at the University of Toronto, the title being *Peptic Ulcers and the Interbrain.* In this paper he established with clarity the fact that peptic ulcers might occur following certain operations on the human brain in the region of the vagal nuclei. In several cases a post-operative fatality resulted from perforation of such peptic ulcers. In summary of his observations he said:

> Those favorably disposed toward the neurogenic conception of ulcer have in process of time gradually shifted the burden of responsibility from the peripheral vagus to its centre in the medulla, to the midbrain, and now to the interbrain, newly recognized as highly important, long overlooked station for vegetative impulses easily affected by psychic influences. So it may easily be that highly-strung persons, who incline to the form of nervous instability classified as parasympathetic (vagotonic) through emotion or repressed emotion, incidental to continued worry and anxiety and heavy responsibility, combined with other factors such as irregular meals and excessive use of tobacco, are particularly prone to have chronic digestive disturbances with hyperacidity, often leading to ulcer — effects wholly comparable to those acutely produced by irritative lesions experimentally made anywhere in the course of the parasympathetic system from tuberal centre to its vagal terminals.
>
> While this conception of the etiology of ulcer does not account for all ulcerative processes under all conditions, it offers a reasonable explanation of the majority of them and is in accord with the personal experience of most victims of chronic recurring ulcer. This, briefly, is as near as one can come, with the data at hand, to an interpretation of the neurogenic origin of peptic ulcer and an explanation of its existing prevalence.

ROLE OF THE VAGUS NERVES

During the past five years Dragstedt and co-workers have done much to further the clinical application of the above thesis. After considerable basic experimentation they were satisfied that in the ulcer patient abnormal adverse stimuli were transmitted from the basal ganglia to the stomach by way of the vagus nerves. They were able to show that the ulcer patient presents three main deviations from normal gastric physiology and that these deviations may be corrected by section of the vagus nerves.

Hyperacidity or increase in the

Dr. Stuart is a member of the medical staff, Holy Cross Hospital, Calgary.

free hydrochloric acid of the stomach is the common denominator of all ulcer-formers. It has been axiomatic that "without gastric acidity there can be no ulcer." Dragstedt's laboratory and clinical experiments have shown that section of the vagus nerves abolishes the secretion of free hydrochloric acid normally stimulated by the cerebral mechanism. This confirms observations from the time of Beaumont that hypersecretion of the gastric juices occurs not only as a result of stimulus of food in the stomach, but from neurogenic sources of cephalic origin.

Probably the most vicious factor in the physiologic disturbance of the ulcer patient is the continuous night secretion in the presence of an empty stomach. Here again this aberration is apparently due to continued vagal stimuli from the subconscious psyche. Clinically this secretion can be ablated by vagus section.

Hypermotility or rapid emptying of the stomach is a common accompaniment to the ulcer diathesis. This disturbance, coupled with a hyperacid stomach, results in a condition whereby the buffering effect of the food is lost too soon. Thus the duodenum may be subjected for several hours between meals to an unbuffered highly acid gastric juice. This hyperactive peristaltic state is of vagus origin and is abolished by vagus section.

We shall now discuss the surgical application of the above principles. Unfortunately the whole cannot be transposed as yet to the operating-table. Certain queries as to late results and undesirable side-effects warrant a conservative attitude. It can be said, however, that a most important chapter in the physiology of peptic ulcer has been initiated.

GASTROENTEROSTOMY

During the last three decades the surgical attack on duodenal ulcer has been characterized by an endeavor to "change the physiology" in the stomach of the ulcer patient. The early methods, involving plastic reconstruction of the pylorus, were followed by poor results. Then ensued the Moynihan era of the gastroenterostomy which appeared to offer for a time a finite answer to the problem. As with most new cures the exponents of this procedure were reluctant to admit its defects. Only after accurate statistics were obtained in large follow-up series was it conceded that the serious complication of stomal ulcer occurred in 15 per cent of cases.

SUB-TOTAL RESECTION

During the last fifteen years the operation of gastroenterostomy has been superseded by that of sub-total resection of the stomach. The record of this procedure has been much superior to that of gastroenterostomy even though the physiologic basis is not too clear. Basically, it may be stated that a marked reduction in the acidity of the stomach results from resection of a portion of the acid-secreting area, coupled with a free ingress of alkaline jejunal contents. This explanation however probably does not embrace the whole truth. There must also be considered the beneficial effect of ablation of the antral gastric mucosa. The importance of this portion of the stomach in the regulation of gastric secretion was appreciated by Eakins in 1906.

Although the results obtained by sub-total gastric resection have been relatively good, the operation is subject to several criticisms. To the physiologist it appears to be a radical procedure, something akin to burning down the house to get rid of the cockroaches. This radical extirpation of gastric mucosa appears to result occasionally in the development of macrocytic anemia. The mortality of the operation averages 5 per cent. Disturbances in the stomal function may cause complaints in 10 per cent of resected patients.

VAGOTOMY

During the last three years section of the vagus nerves, as popularized by Dragstedt, has been performed in many surgical clinics. The physiological principle underlying this operation is that ablation of vagal supply results in inability of the stomach to secrete acid and the harmful night secretion in an empty stomach ceases. At the present time the status of the operation is uncertain due to a welter of controversial opinion as to its merits. This appears to have arisen mainly on account of unpredictable complications which may follow the operation. The most troublesome is that of delay in gastric emptying, which may cause distressing sensation of fullness, belching, fermentative diarrhea, etc. This complication has been of such importance that some surgeons feel that gastroenterostomy should be performed routinely at the time of vagus section. This then necessarily requires that the vagotomy must be done from the subdiaphragmatic rather than the transthoracic approach in the primary duodenal ulcer. Technically, this decreases the accuracy of sectioning completely all the vagus supply on account of anatomic vagaries of the nerves. Vagotomized stomachs, done by the subdiaphragmatic approach, show a fair percentage of failure when checked by the Hollander insulin test. It is, therefore, possible that an ulcer-former might be left with a gastroenterostomy in a stomach whose acid-secreting potential was not abolished. The possibility of formation of a stomal ulcer would still exist.

The remote permanent effect of the operation cannot be assessed for some years to come. The query as to whether vagotomized stomachs, rendered innocuous post-operatively, will remain so may well be pondered. As with the preceding types of surgical procedure, only time and honest appraisal of results will give the true answer.

Pre-Operative and Post-Operative Care in Gastric Surgery

MARGARET MARY FLANAGAN

Average reading time — 5 min. 36 sec.

As a result of newer concepts of pre-operative and post-operative care in gastric surgery, nursing care has become most important. These contributions have helped to reduce the mortality considerably.

PRE-OPERATIVE CARE

The properly prepared patient comes to surgery with improved reserves and is thus better able to withstand the strain of prolonged procedures. Adequate pre-operative hospitalization is necessary for proper preparation. The average patient enters hospital presenting some distress, such as anorexia, vomiting, or pain, and he may often be in a state of poor nutrition.

In the obstructed case, decompression by the Wangensteen nasal suction is a necessary adjunct. Frequently, after a few days of decompression the obstruction may partially release so that appreciable oral intake may be retained. Night feedings may be instilled through a cellophane tube which is less irritating than the ordinary rubber tube. Adequate sedation ensures a minimal disturbance of the patient's rest.

Building up the surgical patient's protein and carbohydrate reserves is of paramount importance. Modern dietetics assumes the responsibility of supervising *accurately* the intake of protein and carbohydrate of the

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Miss Flanagan is a graduate of Holy Cross Hospital, Calgary.

poor-risk patient. Careful dietetic management may be necessary for a prolonged period in order to make the patient safe for surgery. The gastric invalid presents himself with body reserves badly depleted through inadequate food intake over a considerable period of time. He has been forced to use up his own reserves in a process well described as "autocannibalism." Such a patient cannot tolerate lengthy surgery and almost invariably returns to the ward in a shock state which is difficult to control.

Wangensteen and Varco of the University of Minnesota have done valuable research in the dietary management of the surgical patient. The Varco formula in use in this hospital is a liquid medium high in protein and carbohydrate. It is easily digestible, palatable, and relatively inexpensive. The formula and table of equivalents are as follows:

Varco Liquid Diet

P 120.4 F 37.2 C 408.8
Cal. 2446 Vol. 1500 cc.

6 whole eggs
2 egg whites
4 oz. S.M.P.
300 gm. lactose or cane sugar
1000 gm. skim milk
5 gr. salt (may be added when indicated)

For the patient in whom a satisfactory oral alimentation is impossible commercial protein hydrolysate or plasma may be given intravenously. Clinical experience appears to indicate that the oral route produces the most satisfactory response in the patient.

Vitamins: Vitamin C, the healing vitamin, is necessary to the surgical patient. It is concerned with the laying down of the intercellular elements vital to sound tissue repair. The minimum requirement is 100 mgm. daily.

Fluids: A rough estimate of an adequate fluid intake may be considered to be 3000 cc. daily, plus compensation for any extraordinary fluid loss such as that from gastric suction. The urine output should be maintained at a minimum level of 1000 cc. daily.

Blood: Any secondary anemia must be corrected prior to surgery by transfusion. This problem is now being efficiently handled here by the Red Cross Transfusion Service which supplies appropriate blood free of charge to the patient. This excellent service has earned the sincere gratitude of the patients.

POST-OPERATIVE CARE

Following surgery the patient is returned to the ward with an intravenous *in situ*. This allows for immediate supportive treatment with blood or plasma should the circumstance warrant. Nasal oxygen is usually administered until the patient begins to awaken. As soon as the patient has become co-operative, the nasal gastric suction is begun. Gentle irrigation is used periodically to ensure efficient action. The tube is usually left for forty-eight hours. Beginning on the third post-operative day a graduated oral intake is allowed. Careful watch is kept for signs of a full stomach and, if indicated, the nasal suction tube is immediately re-introduced.

In the early post-operative period the patient is encouraged to breathe deeply and is turned from side to side every two hours. Leg exercises are carried out to improve venous circulation. Fowler's position is not considered desirable on account of the tendency for it to increase venous stasis in the legs. Early ambulation is favored on the second or third post-operative day. *This means ambulation and not sitting in a chair.*

An unwarranted rise in temperature, possibly accompanied by cough or dyspnea, may indicate atelectasis. A chest film is taken immediately. If atelectasis is found, the obstructed bronchus can usually be cleared by the passage of a catheter into the trachea. A resistant case may require bronchoscopy. The dramatic relief of the patient's distress is well worth the effort. Many cases of atelectasis can be prevented by encouraging and assisting the patient with mucus in the trachea to cough periodically.

Duodenal fistula, a most distressing and troublesome complication, may be satisfactorily handled. The local excoriating effect of the juice may be minimized by protecting the skin with Kaolin paste. This may be fashioned into a basin which can be drained by a suction device. The modern Gomco silent electric pump is a valuable aid to the comfort of the patient with this difficulty. It is most important to maintain the patient's fluid requirements by intravenous administration, as large quantities of fluid are lost through the fistula. Blood, protein hydrolysate, and vitamins are important to maintain the healing power of the tissues.

Dietary Treatment of Duodenal Ulcer

GRACE MACLELLAN

Average reading time — 4 min. 6 sec.

MR. K is a white male, thirty-five years of age, born in Poland. His father died from a head injury and his mother, still maintaining good health, is at present residing in Africa. He has one sister living in Poland and one brother killed in World War II.

Mr. K resided in Poland until the outbreak of war in 1939; from 1942 to 1944 he was a prisoner in Russia, where he suffered starvation and malnutrition. Following this period he came to Canada and for fourteen months has been working on a farm in New Brunswick.

Mr. K had never been hospitalized previously, nor had any operations, diseases, nor illnesses, until he developed his present condition — duodenal ulcers. He was admitted to the hospital with a history of indigestion, burning pain and distress coming on after meals. These symptoms had occurred periodically for one year.

On the day of admission he was nauseated, with cramp-like pains in the epigastrium. He vomited approximately 1000 cc. of coffee-ground emesis and also passed tarry stools. An x-ray examination demonstrated the presence of a duodenal ulcer. The report from the x-ray stated: "Old duodenal ulcer along the lesser curvature side of the base of the duodenal cap. There is somewhat of a cascade effect between the fundus of the stomach and the main portion of the stomach body." Apparently the ulcer was located near a blood vessel on the stomach wall which ruptured, causing the hemorrhage.

A stool analysis was performed and occult blood found in the specimen. No pathologic organisms were found. Complete bed rest was instituted and a sedative was ordered — phenalone with codeine, tablets 2 every four hours when necessary, to allay the activity and lessen the irritation of the ulcerative area.

Mr. K was admitted to a private room and while there he was depressed, irritable, and tense. One week later he was transferred to a ward with five men and in spite of language difficulties he managed well. He had less time to think about himself and became very congenial and agreeable when approached. He appeared intensely interested in his condition and very willing to cooperate with the treatments. It is interesting to note that while in hospital Mr. K's mastery of English was noticeably increased so that he could converse fairly well with nurses and other patients.

For several days Mr. K was feeling much improved when he complained

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Miss MacLellan is a recent graduate of the Moncton Hospital in New Brunswick.

of headaches, dizziness and weakness, pulse was rapid and thready. A blood count was ordered by the doctor and the report of the laboratory findings was interesting. The red cell count was found to be 3,575,000 per cu.mm, with a hemoglobin of 60%. The red count was somewhat below normal and the hemoglobin was quite low and indicative of a pronounced anemia. The patient was then given 500 cc. whole blood.

Mr. K was gaining in strength day by day and, by order of the doctor, he was allowed up in a chair. Each day following he was allowed more privileges. Unfortunately he contracted a cold and developed a sore throat with some elevation in temp rature. During this time he had general malaise. Nose drops were prescribed and gave relief.

The nursing care of this patient was accomplished most effectively by putting him at strict bed rest, sedating him comfortably, and by cautious attention to his diet and medication schedule, which required the closest co-operation on the part of the patient and the nurse. Ulcer pain is very agonizing and the responsibility for its relief fell upon the nurse whose duty it was to see that the patient received his feedings on time.

The usual medication consisted of Sippy Diet with three ounces of equal parts of milk and cream and two-thirds of a dram of Sippy Powder "B" administered at hourly intervals from morning until bedtime. The therapy was continued through the night, modified in such a way as to ensure adequate sleep. After ten days the diet was gradually increased to small amounts of toast, butter, custard, milk pudding, sieved vegetables and creamed soups. From the fifteenth to the twenty-first day the same food was served but in larger amounts. He was then placed on a bland diet which included chicken, white fish, apple sauce and diluted fruit juices.

It is a well-known fact that, apart from an unfavorable diet, emotional disturbances play a large role in the cause and irritation of a duodenal ulcer. In the plan of instruction for the patient it was important to stress good hygienic habits, the prescribed diet and, above all, the necessity for relaxation as well as the avoidance of fatigue and worry.

At the end of a month of treatment, an appointment was made for an x-ray for recheck examination of the upper gastrointestinal tract which demonstrated essentially the same appearance as noted previously, but represented some improvement. Four days later another blood count was made. The red cell count report was 3,960,000 per cu. mm. while the hemoglobin had increased to 71%.

A week later Mr. K, whose condition was greatly improved, was discharged in care of a Polish friend who would help him carry on his medication and diet.

Treatment of Warts

Warts in children may be divided into three groups for the purpose of treatment:

1. *Verruca vulgaris* (including the filiform variety): The lesions are usually located on the dorsa of the hands and fingers, but may be found about the lips, eyelids, nostrils, or in fact anywhere on the skin surface. If numerous, the method of choice is charming or therapeutic suggestion; if few and isolated, the application of carbon dioxide snow.

2. *Verruca plana:* The lesions are normally found on the hands or face as small, smooth, slightly raised flat lesions, generally multiple and numerous. This type, being small and inconspicuous, hardly warrants treatment, but if such is desired the application of caustics or the internal administration of mercury is satisfactory.

3. *Verruca plantaris:* This form, on the sole of the foot, causes considerable pain on standing and walking. Superficial x-ray with immediate relief of pain and early disappearance of lesions is the only really satisfactory treatment for this type.

Treatment should, if possible, remove the lesions without scarring, pain, risk to the patient, or undue expenditure of time or material in proportion to the benefit derived. The lesions may vanish without trace.

— *R.N.V.R. Medical Press and Circular*

Rehabilitation for Every Patient

C. McG. Gardner, M.D.

Average reading time — 16 min. 48 sec.

The dictionary defines "rehabilitation" as "The restoration to useful activity of individuals who have been wounded so as to suffer from physical or emotional disability, this restoration including (1) treatment of the disability and (2) training to fit the individual for occupation in industry." From this definition it is clearly seen that surgical treatment, far from being the only feature in the cure of the patient, is merely one phase of the process. Rehabilitation in its true sense should commence the very moment that a man or woman takes ill or is wounded.

Rehabilitation is a very old conception. It is recorded in the Acts of the Apostles that, nearly two thousand years ago, Peter said to the lame man who begged alms from him:

> "Silver and gold have I none; but such as I have give I thee. In the name of Jesus Christ of Nazareth, rise up and walk." And he took him by the right hand and lifted him up: and immediately his feet and ankle bones received strength. And he, leaping up, stood and walked, and entered with them into the temple, walking and leaping, and praising God.

One cannot read these words without a feeling of awe and wonderment that the whole process, on which so much time and effort is spent today, should have been accomplished in a few seconds. Nevertheless this is the end towards which we strive. The words "rise up" could well be interpreted as the actual cure of the patient's ailment, "and walk" the restoration of the individual to full usefulness.

For many years human life has been so cheap and expendable that little thought or effort had been devoted to this idea. As is true with many cheap commodities, it was easier to create a new one rather than repair the old. The country doctor at the end of the nineteenth and the beginning of the twentieth century attempted to make the best of difficult situations and restore patients to some semblance of their former usefulness, but he was greatly limited by the fact that, the first part of the process—the actual cure of the disease—was restricted, by limited knowledge, to so few maladies. Modern therapy really dates from the beginning of the twentieth century. Stimulated by a constantly increasing number of new scientific facts, practically all efforts of medical men and their associates since 1900 have been devoted to the investigation and therapy of deadly diseases, to an extent that the patient himself and his future were largely forgotten in the process. In other words, as the science of medicine progressed, the art was forgotten and if a patient's malady could not be scientifically dealt with, there was a tendency to forget him.

Again when it was felt that no spectacular cure would be obtained or no brilliant diagnosis made, or even when this latter was achieved but no rapid form of therapy for the particular disease was known, the pressure became so great that many patients were sent home without any attempt at rehabilitation or resettlement with the pious hope that the Lord or some kind friend would provide. Shylock's famous maxim — that "you take my house when you do take the prop that doth sustain it; you take my life when you do take the means by which I live" — was not considered to be the concern of a physician or surgeon.

Hence many operations, or other forms of therapy which were consi-

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Dr. Gardner is associated with the Queen Mary Veterans Hospital in Montreal.

dered to be eminently successful by the doctor, seemed from the patient's viewpoint to be lamentable failures. He might often believe it better had he never been treated at all, as even death itself could appear preferable to the disablement and financial hardships sometimes endured because, once having left the hospital, very little further interest might be taken in him.

About ten years ago my interest became awakened in the lives of some of the patients subsequent to hospitalization. Very soon I began to realize that no matter how brilliant the physician or surgeon, or how efficient and devoted the hospital, the medical profession should reach out into every person's home — first to find the origin of disease (which has no part in this discussion) and, second, to make sure that therapy was carried on until the patient was restored to his job. Because of inadequate distribution many of the brilliant scientific discoveries reached and cured only a few people. Because of insufficient rehabilitation and follow-up, a large number of others were only partially aided who should have been restored to full economic efficiency.

What use is it to save a man in diabetic coma and let him die slowly later of multiple infections because his diet and insulin are improperly supervised? What does it profit to save the life of a severely burned man only to give him back to his family, as a millstone around their necks because he cannot use his hands? What advantage is it to cure a gastric ulcer when one knows it will surely recur because of inadequate rest and improper diet? While, therefore, it is vitally important that research in medicine should progress, it seems equally important to apply to as many sick people as possible, as thoroughly as possible, the knowledge already gained.

Ideas as to how this might be done were slowly taking shape when, with the war, a highly trained technician in any field became practically priceless. This was particularly true in the Air Force. The "few" were, for a time at least, irreplaceable, and, under the able leadership of Sir Reginald Watson-Jones, a plan was evolved to establish centres where wounded airmen could be restored to full function. This plan, at first divided into sections, and carried out in a more or less uncertain manner, was soon streamlined so that the moment an injured pilot arrived at one of these Air Force hospitals his rehabilitation program commenced. His retraining was initiated at the same time as the treatment for his injury. The system finally reached a point where the majority of all injured pilots were returned to full duty. However, it must be borne in mind that all or most of these men were being retrained for the positions which they formerly occupied and also that the scheme was backed by the full force of the government with no financial limit.

At the same time Professor John Ryle of Oxford University was studying rehabilitation as applied to civilians, and it is due, to a certain extent, to his stimulus and that of others like him that our present scheme of rehabilitation under D.V.A. has progressed as far as it has.

The main factor in the production of properly rehabilitated patients is team-work and, unless this principle is accepted in the beginning, nothing can be accomplished. The day of the master surgeon is at an end. Every single soul working in a hospital, or in the subsequent handling of patients either in a convalescent hospital or a home, must realize that he or she is an integral part of the therapeutic process. If one thinks for a moment one realizes at once that, unless the building is heated by the engineers, unless the diets are properly prepared by the dietitians, unless the instruments are properly sterilized by the nurses or orderlies, not one single cure would be achieved. In fact, almost everyone is equally necessary and equally important.

Here, then, is the vital factor. We must establish a hospital or medical group where the bond of friendship between the people working within is so strong that they are prepared, if necessary, to sacrifice some of their individual ambition and freedom in order that the patients may be speedily restored to full usefulness and that the hospital may successfully carry out its mission. Not only is this true, but every worker in a hospital or in the field must be educated to realize the importance of each other's work: the occupational therapist is as important as the surgeon, the secretary as the nurse because all are interdependent.

Just a few words then regarding the goal towards which we are moving. We have not by any means achieved this goal. Every step forward is made at great cost and in the face of considerable opposition. The idea of assuming responsibility for a patient until he is actually ready to resume work is being seriously considered for the first time. Medical care till now has been largely emergency care and, the emergency once over, the patient was left to fend for himself or at best was followed in a more or less desultory fashion by a doctor or in an outdoor department. Having committed this crime of omission many times myself I know whereof I speak. Many times have I presumed, through wishful thinking, that a patient of mine was well, happy, and economically safe only to find that, because he had not been adequately rehabilitated, he had become a beggar or an inmate of some charitable institution. I sometimes wonder whether the sin of omission is not more serious than that of commission. At least the latter is more often in the open where the conscience of the people as a whole, if not the law, may finally avenge it. But the former is silent. We sin by remaining silent. It is so much easier to let things rest in *statu quo*, quieting our doubts by the platitude that "it has always been done this way before, and after all we, you and I, are doing more than some people, and anyway what could we do about it?" So we sit watching our brilliantly conceived treatment fail because we feel it isn't our job to see it carried through.

What then can we do, you say? A thousand things at least but I wish only to outline a few immediate practical suggestions, leaving aside for the present the broader issues. The moment a patient is admitted to hospital he should be seen, not only by doctors and nurses, but also by a rehabilitation officer who will, in conference with the doctor, decide what the future of the man is likely to be — whether he will return to his former job or perform some lighter one of a specific type, or whether he will no longer be able to resume his place in industry. At the same moment that the doctor is planning the medical treatment, the rehabilitation officer should be planning the man's social re-establishment. At once a physiotherapist, occupational therapist, recreational expert, educational officer, a representative of industry, and any other specialist required should be called in to voice opinions in order that no time may be wasted. A social service worker is absolutely indispensable to supply all relevant information concerning the man's family and his background. It is strange that while we have learned to use specialists so freely in treatment itself, in rehabilitation they are hardly thought of.

A detailed plan is then worked out and everyone concerned with the patient's treatment, rehabilitation, and resettlement should be informed of this plan, so that his medical treatment and social restoration will march hand in hand.

We hope some day to have a rehabilitation officer with such a staff that he will be able to say at any moment of the day where *every* patient in the hospital is and what he is doing and to make sure that he is occupying his enforced stay as usefully as possible. In other words, a man's time-table in hospital should be similar to that at his work. If he has physiotherapy from 9 to 10, he should have occupational therapy from 10 to 11, an educational course, perhaps, from 11 to 12, and so on. In this way the stage of medical treatment unconsciously passes into the stage of social restoration. Almost before he knows it, the injured man has resumed either his former job or is in some new one better suited to his changed body and mind. He may be moved from the active treatment hospital but should be attended by the same team until his resettlement is complete.

In the meanwhile the social service worker assures herself that his dependents are being cared for adequately. Nothing is so conducive to delay in healing as a troubled mind, nor is anything more apt to prevent a man from following his treatment till restoration is complete. I can only again quote the words of Watson-Jones when he says: "A doctor should consider himself to have failed in his duty to his patient if he does not see him restored to at least the physical and mental fitness which he had before the accident and to a position in industry which may be different but is of equivalent value." This is a colossal aim but if attempted in all cases can be achieved in many, indeed, perhaps in most.

Browning said: "O that a man's reach should exceed his grasp, or what's a heaven for?" and surely no nobler purpose can be imagined than the restoration to integrity of a man's broken body, mind, or soul. Any of you who have seen the fear in a young man's eyes after he has been wounded know that he fears not death, but disablement and economic dependence. He is afraid of becoming a liability instead of an asset. Nothing seems to destroy a soul as quickly as this fear and if it can be dispelled at once, by a well thought out and complete plan of restoration, the battle is half won.

What a difference is here from allowing a man to lie in bed for a period varying from two weeks to five years, while he rots physically and mentally to such an extent that when eventually he is discharged, medically cured, he is no longer fit to take his place either in industry or in his home because of mental and moral deterioration!

It might seem from the tone of these words that I am pleading for rehabilitation and resettlement from purely philanthropic or altruistic motives. These motives are self-evident as I do not believe that anyone will deny that every man and woman has the right to liberty, equality, and the pursuit of happiness, and that none of these can be achieved without the first essential — reasonable health.

But there is still another and quite as potent an argument for the proper reconditioning of the sick or disabled person. Recently in New York, a group of people were taken from the relief rolls, where they had been placed because of physical and mental disability. They had been costing the state about $1,500 a year. By the average expenditure of some $300 on treatment and retraining, these men and women were transformed into actual wage-earners so that the net saving to the country per year now averages $2,000 per individual. When the dividend to the state on a $300 investment is $24,000 in the average lifetime of each individual so treated, the total figure becomes staggering in its immensity. If this can be achieved with a limited group of people there is no reason why it cannot be achieved for the vast majority of all sick and disabled people.

One more very practical reason may be stated. Many people with an infectious disease, such as tuberculosis, are now discharged from hospital before their treatment and restoration is complete, and at present constitute one of the greatest menaces to the nation's health, costing Canada an untold sum of money. Therefore, although perhaps in the beginning proper rehabilitation might cost us, the electorate, a considerable number of dollars, I believe, though I cannot prove, that in the course of twenty-five years we would have gained back not only our original financial outlay, but considerable interest as well, and a dividend in human happiness wonderful to contemplate.

This is not all theory or conjecture. We have already taken perhaps the most seriously disabled group — the paraplegics — and worked with them, believing that if they could be rehabilitated anyone else could be. You must all know by now of the success of this effort. Due to the untiring and selfless leadership of a few inspired people with the help of previously described co-ordinated effort, these, the living dead, (always previously abandoned to eke out their miserable days as helpless invalids, a curse to themselves, and a burden to their families and to the state), have today literally risen from their beds and walked. Space does not allow me to detail even a single case but each one is an inspiration to anyone interested in rehabilitation. The obvious desire, here strikingly illustrated, of the average individual to help himself if only given a sporting chance by his fellows, gives the lie to those who would demean the spirit by stating that men will not work unless they are either hungry, afraid, or greedy.

I have outlined the general aim and plan of rehabilitation. What we are trying to do in D.V.A. is to carry this out. Let no one feel that the situation is mastered. Not a day passes that one is not frustrated and balked by ill-will, inefficiency, and inertia. But we have at least started. Probably I may not live to see the final triumph but it will come. Some say "What if it all fails?" and I would answer with Shakespeare's words, "If we fail, we fail! But screw your courage to the sticking point and we'll not fail!" Meanwhile, everyone in the organization — doctors, nurses, orderlies, physiotherapists, occupational therapists, rehabilitation officers, social service workers, educational officers, recreational people, secretaries, workers in the library, photographic and x-ray department and the laboratory, those who are responsible for the maintenance of the building and those who feed the patients, all of the administrative staff and the government itself — either understand the principle or are interested by its workings, and all these groups of people are working side by side in harmony to produce this general welfare for mankind.

This surely is a vision of the brave new world for which we fought. This is the great positive idea expressed two thousand years ago for which we can all work, and we were given a slogan or perhaps even a command in the one brief sentence: "Thou art thy brother's keeper."

℞ *Chuckles* P.R.N.

Viability is the age at which the fetus may be expelled and live on its own hook.

Treatment for tuberculosis of the larynx: wire patient's teeth together so they can't move and put a plaster cast on his neck.

Labor is what the doctor does to deliver a baby.

The eustachian tube is a passageway between the mouth and the stomach.

Cautery means to clot the blood.

Diaphysis means difficult breathing and epiphysis is breathing easier while sitting in an upright position.

Dysuria is the amount of color secreted in the urine sometimes during a test.

The patient had an invertable dish in her spine.

A disinfectant is anything that will kill bacteria and their squaws.

There are two ways of living. A man may be casual and simply exist, or constructive and deliberately try to do something with his life. The constructive idea implies constructiveness not only about one's own life, but about that of society, and the future possibilities of humanity. — Julian Huxley

Drug Therapy

M. Wholey

Average reading time — 14 min. 12 sec.

In the past two years the progress of pharmacy has been so great that an attempt to review the many advances would be hopeless. In order that I may indicate the trend of this progress I have chosen to discuss several drugs.

PENICILLIN

New antibiotics from many sources are constantly being reported and the widening circle of investigation indicates that workers in this field are still on a therapeutic frontier. *Streptomycin*, obtained from the soil, is proving valuable in the treatment of infections due to susceptible gram negative organisms. Its position still needs clarification in many conditions but it appears to be a very useful drug. *Penicillin*, which is effective against most gram positive organisms, is quite well known. Two advances in penicillin therapy come to mind which are not as familiar as the penicillin throat lozenge therapy or the q.3.h. intramuscular treatment. The primary objective of penicillin therapy is the maintenance of therapeutic concentrations of the antibiotic in the body tissue. It is difficult to attain elevated concentrations because of the rapidity with which penicillin is absorbed from the site of injection and excreted by the kidney. Effort has been made to maintain plasma concentrations above the commonly accepted therapeutic level in several ways:

1. Increasing dosage.
2. More frequent injections.
3. Route of administration — i.e., intramuscular drip.
4. Slowing absorption — i.e., beeswax in oil.
5. Suppression of the excretion of penicillin by the renal tubules.

In connection with the slowing of the absorption of penicillin a new product *procaine penicillin* is now available which differs from the commonly known sodium and potassium penicillin in that therapeutic blood levels may be maintained for at least twenty-four hours following a single injection. Caronamide is a drug which, when given orally to patients receiving penicillin, results in the elevation of the concentration of penicillin in the plasma. It acts by inhibiting the penicillin excretion by the renal tubules.

SULFONAMIDES

In spite of the appearance of penicillin and other antibiotics, the sulfonamides continue to be very valuable systemic anti-bacterials. The danger of the formation of crystals of these drugs or their acetylated form in the urine is commonly known. The solubilities of *sulfathiazole*, *sulfamerazine*, *sulfadiazine*, and the acetylated derivatives become significantly greater when the urine becomes moderately alkaline. Suggestions for the prevention of crystalluria, due to sulfonamide crystals, have included the following:

1. Low dosages of sulfonamides.
2. Increase the volume of the urine by increasing fluid intake.
3. Alkalinization of the urine.
4. The use of sulfonamide mixtures.

The objection to the first of these suggestions is that inadequate doses of sulfonamides not only fail to cure the infection, but may render the infecting organism sulfonamide-fast. The fourth method of preventing crystalluria is through the use of sulfonamide mixtures. This depends upon the recently observed fact that a mixture of two or more sulfonamides in the tissue fluids will have an added bacteriostatic effect and that

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Miss Wholey was pharmacist at the University of Alberta Hospital at the time this paper was prepared.

they will permit ample dosage with lower toxicity. Preparations are now on the market which contain equal parts of the three sulfonamides mentioned above. Investigations indicate that the triple sulfonamides are safe without alkali when the dosage is 4 to 6 gm. daily. The necessity of maintaining an adequate urinary output is still important. It should be remembered, too, that it is the output, not the intake, which is decisive. The average adult, on 6 gm. of triple sulfonamide mixture, should excrete 1500 cc. or more of urine daily. The principle of added therapeutic effect, along with almost independent solubility of sulfonamides in a sulfonamide mixture, makes adequate therapy much safer than in the past.

THIOURACIL

The discovery of the various thyroid inhibitors — *thiouracil* and its derivatives — is the direct result of a chance observation of the effect on rats made in 1941. The action of these sulphur compounds, now under continuous and intensive investigation, has been the subject of an ever-increasing number of reports, all of which state their positive therapeutic value in thyrotoxicosis. Instances of unfavorable reaction have been reported. These have served to curb over-enthusiasm, but they have not interfered with the orderly progress tending to establish the true therapeutic value of these new chemicals. It has been definitely established that the physiologic action of these compounds is to block or inhibit the formation of thyroxin. They do not interfere with the action of the thyroxin already formed. Hence, it is that their inhibitory action does not become apparent until the thyroxin already formed has been completely used up or has undergone decay. While thiouracil has proved a very effective antithyroid drug, the fact that its administration has been associated with toxic effects in about 10 per cent of cases treated, has discouraged its use and at the same time stimulated the search for a preparation as effective as thiouracil, but without the danger. Among the derivatives studied ***propylthiouracil*** appears to be the most satisfactory. It is indicated for the treatment of thyrotoxicosis both preoperatively and as medical treatment. Caution is still necessary during its use and blood counts and basal metabolic rate determination should be made frequently. In patients under treatment for long periods, signs of hypothyroidism should be watched for and, if these should appear, the dose should be reduced or omitted for a short period and resumed at a lower level.

DICUMEROL

There has been a long-felt need in therapeutics for a suitable anticoagulant to prevent the development of intravascular thrombi in vessels damaged by either infection or trauma. The search for such a substance led to the use of ***dicumerol***. Investigators have demonstrated that, in a number of instances, this drug prevented the formation of thrombi or reduced the tendency towards the extension of preformed thrombi. Its prolonged action, effectiveness by mouth, and economy are conducive to simplicity of treatment. Certain precautions are essential in dicumerol therapy: First — the use of dicumerol should be restricted to hospitals providing: (1) facilities for daily prothrombin time determinations, and (2) facilities for the immediate transfusion of fresh whole blood of a compatible type.

Transfusion of fresh whole blood and very large doses of synthetic vitamin K (*Menadione Bisulfite*) are the only antidotes for dicumerol overdosage. This overdosage will result in hemorrhage. The effect tends to be cumulative and prolonged. Dosage must be controlled at all times by daily prothrombin tests and adjusted to the needs of each individual on the basis of laboratory findings. It is a very useful drug but its use must be carefully supervised.

ANALGESICS AND SEDATIVES

The past few years have included intensive research into a further conquest of pain that would minimize the age-old problem of narcotic addiction. High on the list of new drugs recently introduced for this purpose are *metopon* and *demerol.* Metopon is one of the most promising new morphine derivatives. It has been released to physicians for the control of cancer pain. It is similar to morphine in the fact that it may cause addiction. The advantages of its use are:

1. Its high analgesic effectiveness.
2. The absence of nausea and vomiting.
3. Absence of mental dullness.
4. Slow development of tolerance and dependence.

A significant consideration is that metopon is highly effective orally. It is controlled by the Narcotic Division and is available in tablet form. It appears to be a valuable drug in the control of pain in malignant disease. Demerol, a synthetic compound, has been found useful as an analgesic. It is significant because it is the first compound which is truly effective as an analgesic which is not a morphine derivative. It possesses three main actions: analgesic; antispasmodic; and sedative. When judging its ability to relieve pain, demerol ranks between morphine and codeine. The antispasmodic action contributes to the rapid relief of colicky pain without the undesirable constipation commonly seen after opiate therapy. The sedative action is definite. It is habit-forming but carries with it slightly less risk of addiction than morphine. While newly-available analgesics ease the suffering of advancing cancer victims, treatment remains inadequate. Radioactive isotopes are being used in cancer investigation which is progressing at a steady rate.

Epilepsy Control

Developments in the treatment and control of epilepsy are also interesting. Two chemicals, *tridione* and *mesantoin,* have been recently used. Tridione was found to be of value in *petit mal* seizures but, from numerous untoward effects which have occurred during treatment, its use appears to be limited. Mesantoin is chemically related to *dilantin.* It, too, is effective in *grand mal* seizures and is less toxic than dilantin.

Allergies

Many allergies are believed to be caused by the release of histamine in the body. The mechanism of this release may be briefly described as follows: When an antigen, to which a patient is sensitive, enters his system, certain antibodies, called reagins, are formed which are responsible for the allergenic wheal. Simultaneously, a protective antibody may originate and this accounts for the improvement of the disease. The combined action of the antigen and the specific reagin, in the blood stream or in the tissues, releases histamine and histamine-like substances which dilate capillary blood vessels and induce smooth muscle spasm, especially bronchospasm. Thus, through the action of histamine, the characteristic symptoms of allergy are produced. Secondary infections may supervene, as in chronic sinusitis, bronchial asthma, and allergic eczemas.

The well-known remedies for allergic diseases are designed to interfere with one or another of these phases in the development of the disease. One may attempt to eliminate the antigen from the patient's surroundings and from the diet. One may try to produce the protective antibody by hyposensitization. Attempts have been made to counteract the effect of the histamine in the chain of events. The enzyme histaminase (torantil), which destroys histamine *in vitro,* has not proved to be of clinical value. Efforts toward building up an immune substance against histamine, by injecting increasing doses of either histamine itself or of histamine linked with protein, have also met with little success. In 1933, compounds were discovered which counteracted the action of histamine. Many have been discarded because of toxicity. The most promising ones are *antistin, pyribenzamine,* and *benadryl.* These drugs counteract most of the physiological effects of histamine. They do not chemically neutralize histamine nor do they prevent its production in the body. They are believed to compete with histamine in its affinity for the cells. This group of drugs would be of striking benefit were it not for the fact that some degree of secondary infection usually becomes superimposed on the primary allergic condition. Side reactions of drowsiness and dizziness are more frequent with benadryl and antistin than with pyribenzamine. It has become evident that the anti-histamine drugs deserve a definite place in the management of allergic diseases. They do not, however, in any way affect the course of the disease and they do have unpleasant side effects. Perhaps the greatest significance in their development is the new principle which has instigated their trial, and which will lead to further understanding of the mechanism of allergic disease and perhaps to further therapeutic success.

Public Relations

January 17 marked the beginning of the in-service program sponsored by the Brockville Chapter, Registered Nurses' Association of Ontario. The response by members of the nursing profession and allied professional groups was overwhelming. The first session was officially opened when Miss M. G. Purcell, chairman of the Brockville Chapter, introduced Miss Mildred Walker, who spoke to an enthusiastic group of over sixty on "The Nurse and Public Relations." Even greater response was evident at the evening session, held in the General Hospital classroom, when over 120 gathered to hear Miss Walker when she repeated her lecture for the benefit of those unable to attend the afternoon session.

Miss Walker's address on public relations was educational, constructive, and thought-provoking to all present. She defined public relations "as any situation, act or word that influences people. The public relations of an institution are the sum total of all impressions made by the institution itself and the various persons connected with it. The appearance, action, speech, and writings of every person associated with the institution contribute towards the general impressions as well as any adverse opinions created by any members of that institution." Miss Walker went on to say that "the motivating force in public relations is not factual. We are dealing with opinions formed from other people's ideas. It is important then *who* gives the ideas and *what* ideas are given. Who gives the ideas about nurses and nursing? It should be nurses, but they have been trained to be self-effacing, so they leave it for others to do. Nursing has need of a planned public relations program."

Many have the impression that publicity is public relations. Miss Walker says this is not so. Good publicity, to be constructive, is based on sound public relations. Publicity so based will give added strength to public relations already strong. Good impressions are cumulative.

Methods:

1. Good public relations begin at home.
2. The Golden Rule is the way of all public relations success.
3. It is the way of life for a whole institution.
4. Public relations involve ability to take criticism, admit needs for improvement and do something about it.
5. Public relations are most effective when they demonstrate that the institution is keenly aware of its social and moral obligations.
6. Public relations, like morale, is compounded of many little things —"the things which count the most are the things one cannot count."
7. What one does must be in line with what one says.

Miss Walker advocates the positive approach. "The positive approach is thinking creatively. Avoid the negative approach: e.g., it is better to evaluate a nurse by her strengths and where she needs further strengthening rather than emphasizing her weaknesses."

Miss Walker summed up her lecture by stating that the needs in nursing, which a public relations program could assist, are:

1. Need for qualified personnel to plan public relations program with a conscious awareness of participation by all members of the profession.

2. Need for greater unity of purpose in nursing services. There is too great isolation of services in the thinking of our nurses.

3. Need to use the positive approach.

4. Need for respect for the integrity and personal worth of each nurse as an individual.

5. Need to learn to build friendly relationships.

A Travelling Clinic

In keeping with its policy of preventive medicine for the welfare of its employees, Canadian National Railways has added a new all-steel medical car to its fleet, Dr. K. E. Dowd, chief medical officer, has announced.

With a length of seventy-two feet, the car is divided into three sections and is office and home for Dr. Harrison of the C.N.R. medical department. At one end of the car is the waiting-room for patients. It is furnished with chairs, table, and curtains, and the floor is covered with linoleum. A corridor, leading from the waiting-room to the combination living- and dining-room, also gives access to the examination room, kitchen, bathroom, and bedroom.

The examination room has an enclosed dressing-room and built-in examining table. Equipped with the latest instruments for physical examinations, the medical car also provides the necessary facilities for testing vision. The examination room has a medicine cabinet equipped with first aid medicinal supplies, a sink with running water, a desk, chairs, and a filing cabinet. Completing the equipment is a glass-topped table and instruments for the doctor's use in making analyses.

Next to the examination room is the doctor's bedroom and just past it is the bathroom, with its tub, shower, and locker.

(*Concluded on page 378*)

Photo Courtesy of C.N.R.

In the examination room are, left to right, E. R. Battley, chief of motive power and car equipment; Miss B. Boudreau, of the medical department, and Dr. K. E. Dowd, chief medical officer of the company.

Private Duty Nursing

The Nurse at the Pharmacy Door

SISTER M. ANCILLA, PHM.B.

Average reading time — 12 min. 12 sec.

THE HOSPITAL pharmacist pays tribute, long overdue, to the nursing profession: to the nurse's alertness in keeping herself informed of the latest therapeutic developments, her adaptability to constantly changing trends in treatment and technique, her "teachableness." In particular this appreciation is directed to the hopeful throngs which blossom forth each term in probationers' blue and white.

The pharmacist, it is true, is not always patient with the student nurse's struggle with dosage and percentages, her carefree way with a decimal point as something which may be taken or left behind at will. He may be inclined to overlook the fact that her profession is nursing and his is pharmacy, and that she is not expected to be as familiar with pharmaceutical arithmetic as he must be. Her original spelling and terminology may give him cause for humor, but usually he will be willing to admit that, if enthusiasm and eagerness to learn be healthful signs, a favorable prognosis may be given for the nursing profession of tomorrow.

Day-to-day observations and inquiries from the nursing staff give the hospital pharmacist an idea of common difficulties which nurses encounter in the administration of drugs. Some of these are treated briefly herein, with no apology for repeating oft-told tales.

ALCOHOL

The introduction of isopropyl alcohol to replace ethyl alcohol for sterilizing purposes on the wards and for rubbing alcohol in most hospitals has occasioned some inquiries. Isopropyl alcohol has several advantages over ethyl alcohol in that it is non-potable and, therefore, not subject to the abuse that was associated with ethyl alcohol. It is cheaper and it is effective in lower dilutions, 50% isopropyl being considered equivalent to 70% ethyl alcohol. It does not affect the potency of insulin and can be used as a disinfectant in connection with the administration of all types of insulin; because of lower surface tension and greater fat solvent properties it has more rapid killing power on many organisms and is considered to be twice as efficient as ethyl alcohol as a skin disinfectant. On the debit side we may list the unpleasant odor. Some hospitals endeavor to deodorize isopropyl alcohol for rubbing purposes by the addition of modifiers.

The limitations of alcohol as an antiseptic must be kept in mind. Its property of coagulating protein makes it locally toxic to tissues; consequently bacteria may be protected from its effect. Alcohol is not to be recommended for cleansing wounds of bacteria, dirt and grease. It is ineffective, of course, against spores, and its use to sterilize rubber caps of vials is not reliable. Brief immersion of instruments in alcohol or wiping with an alcohol sponge does not guarantee sterility.

ZEPHIRAN

Tinctures of quaternary ammonium compounds, such as zephiran chloride, are becoming increasingly popular for

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Sister Ancilla is in charge of the pharmacy at St. Joseph's Hospital, Hamilton.

pre-operative disinfection of unbroken skin. Because of low surface tension these solutions are superior detergents and permit greater penetration than other types of disinfecting preparations, but it should be stressed that their action is inhibited by soap. Whenever soap solutions are applied in skin preparation, they should be removed by rinsing, preferably with alcohol, which diminishes ionization of soap and prevents chemical union of soap with zephiran chloride.

Topical use of sulfonamide has declined sharply, but there is still need for the warning that sulfathiazole ointments should not be used beyond a period of five days, because of danger of sensitization.

INSULIN

Globin insulin, recently released in Canada, resembles protamine zinc insulin but is less prolonged in effect, while onset of action is less prompt than that of unmodified insulin. It may be used for patients sensitive to protamine zinc insulin but, like the latter, it cannot be given intravenously.

The pharmacist is involved frequently in the discussion of technique to be employed when unmodified and protamine zinc insulins are to be administered simultaneously. The recommendation has been to use separate syringes; where only one is available, the unmodified insulin should be given first, the protamine zinc insulin last, a second needle to be used if possible. The reason given is that if the two are combined in the same syringe, the unmodified insulin will be absorbed in part by excess protein present in the protamine insulin, with resulting imbalance. Because of much study and clinical work done on admixtures of the two insulins in the same syringe, it is now becoming common practice for some physicians to use them thus combined. The action of the combined insulins begins less abruptly than regularly and lasts less long than protamine zinc insulin alone, and the effect produced is not the same as that obtained from the two doses given singly. By altering the proportion of one type of insulin to the other, the physician is able to suit individual needs. The commonest mixture is two parts regular to one part protamine zinc.

Naturally, the administration of this combination is more difficult for the nurse. The usual practice is to withdraw the protamine insulin first. Since adjustment of the dose of regular insulin then to be drawn into the syringe will be difficult because of the vacuum produced, air is injected into the bottle of regular insulin, the same number of units of air, so to speak, as of insulin to be withdrawn. The correct dose of regular insulin is then drawn into the syringe containing the protamine zinc insulin, and the mixture administered.

METHADON

Methadon, the synthetic analgesic recently released, promises to find a place among those drugs used daily on the wards. A few points may be kept in mind in administering methadon:

1. It is a narcotic and must be handled as such.
2. It resembles morphine, its analgesic properties lying between morphine and demerol, while it gives less sedation than either.
3. Methadon, like morphine, depresses respiration and produces constipation, nausea and vomiting, and is miotic in action, all to a lesser degree than morphine. Other side-effects are lightheadedness, drowsiness, dryness of mouth, sweating, and mental depression.
4. It is effective by either parenteral or oral routes and it is available in tablets and ampoules. Methadon in 10 mgm. doses approximates the analgesic properties of 1/6 gr. morphine sulphate.
5. Indications for use are post-operative pain, renal colic, and other types of pain, including that associated with carcinoma, where absence of tolerance is advantageous: the same dose produces equal degrees of analgesia after many days' treatment. It is of value in suppressing the cough reflex.

6. It is *not* recommended for pre-operative sedation or for use as an analgesic in obstetrics.

UNIT POTENCIES

In administering preparations, of which potency is expressed in units, the nurse will be careful to requisition and to chart them in that way. One cc. of liver extract, for example, conveys no meaning without potency — 2, 10 or 15 units per cc. The same applies to ampoule preparations which have their potency expressed in weight. Progesterone 1 cc. may vary in strength from 5 to 25 mgms. Again, 1 cc. of a digitalis preparation without mention of strength means nothing. "Digitoxin 0.2 mgm. I.V." supplies the information required. No other single omission occasions so much delay in the filling of requisitions in the hospital pharmacy as lack of these specifications.

PENICILLIN

Multiplicity in the forms of penicillin available has complicated penicillin therapy for the nurse. Only patient attention to instructions, issued with the various forms, will guarantee successful administration. For procaine penicillin in oil and aqueous suspensions of procaine penicillin crystals, the general precautions are thorough shaking of the vial and the use of needles of sufficiently large gauge — 19 or 20.

Topical use of penicillin is decreasing in popularity because of the danger of sensitizing the organisms responsible for the infections. When penicillin is used for compresses or other topical purposes, the nurse will keep in mind that it is inactivated by strong acids, alkalis, oxidizing agents such as Dakin's solution, hydrogen peroxide, potassium permanganate, and alcohol.

STREPTOMYCIN

In streptomycin therapy, the first care is to avoid resistance or "fastness" of the organism to the drug; to ensure this, sufficiently large doses are given to kill or inhibit the organism quickly. When streptomycin is used to treat urinary infections, it is useful to remember that alkalinization of the urine increases the anti-bacterial effect of the streptomycin many times; sodium bicarbonate or other alkali may be used. An increasing number of sensitivity reactions, due to streptomycin, is being reported among nurses and others handling the drug. Symptoms are: an initial erythema of the hands, followed by itching and a rash transmitted to the face by contact with unclean hands. The use of rubber gloves and hand-washing before and after handling streptomycin are recommended where any sensitivity has been noticed.

INTRAVENOUS THERAPY

During I.V. therapy, it is not unusual practice to introduce other parenteral medications into the I.V. tubing. Warning should be given of the danger of air embolism if the tubing is clamped off near the flask, creating a negative pressure when the medication is introduced through the tubing. This hazard may be eliminated if the tubing is clamped off at the bottom close to the needle and the tubing penetrated between the clamp and the needle, so that a positive pressure is created. Care must be taken also to expel air from the syringe before introducing the needle into the tubing.

SULFONAMIDES

Sulfonamides are still widely used, alone and in conjunction with penicillin. A recent trend has been to use combinations of sulfonamides to reduce danger of renal toxicity. It has been found that a saturated solution of one sulfonamide will dissolve as much of another as pure water will. Thus, two sulfonamides may be dissolved to the limit of their solubility in the same solution independent of the presence of the other. The total dosage of the combination is the same as of a single sulfonamide. The danger of kidney damage from the mixture of drugs is proportional to the amount of the individual drugs given, not to the total of the two administered. Combinations of two or three sulfonamides are in current use in tablet and liquid forms for oral use. Many claim that sulfadiazine, with adequate alkali intake, gives no higher incidence of renal complication than a combination. Kidney damage may be prevented or reduced by maintaining a urinary output of not less than 1000 cc. per day and by concurrent use of sodium bicarbonate 1.5 gm. for every gram of sulfonamide administered.

OPHTHALMIC DROPS

Nurses frequently experience difficulty in preparing extemporaneous solutions of penicillin for ophthalmic use or for compresses. Since potency diminishes rapidly following wide dilutions of the penicillin, it is better to prepare ophthalmic drops freshly than to requisition a prepared solution which must be used for some time. Where solutions are supplied in dilution of 20,000 units/cc. and drops 5000 units/cc. are required, 1/4 cc. may be withdrawn from the 20,000 unit vial and entered on the penicillin sheet. This 1/4 cc. containing 5000 units is then diluted in the syringe with sterile saline to 1 cc., giving desired strength of 5000 units/cc. This solution may be used for two- or three-hour periods and discarded, a second 1/4 cc. of penicillin (5000 units) withdrawn and diluted as before. In this way a fresh solution is available with very little loss. For compresses the same procedure may be followed, using 1/4 cc. penicillin solution diluted to 10 cc., giving dilution of 500 units/cc.

Canadian nurses have enjoyed a favorable reputation at home and abroad for many years, and new members of the profession must be prepared to meet appraisal and critical evaluation of their abilities in the light of this high regard. It is a sobering thought. If we can help her to achieve a greater degree of technical skill and knowledge, more faithful adherence to standards of excellence set by her predecessors, hospital pharmacists are happy to answer the nurse's queries.

In the Good Old Days

(*The Canadian Nurse, May, 1909*)

"I should like to say a word for trained nurses. They differ, of course, like every other class taken from our imperfect humanity. But on the whole, I do not believe that any other vocation develops in women equal sagacity, skill, and delicate manifestations of tact and sympathy. And, while there are probably those who fail to appreciate them, I think they have the regard and in many cases real affection of the great majority of their worthy patients."

* * *

"The different associations of graduate nurses in British Columbia are preparing a bill for registration to be presented at the next sitting of the local House."

* * *

"Our probationers come to us one at a time as required and, as we have no properly equipped diet kitchen or demonstrating room, they are taken at once to the wards. The superintendent, coming as she does in daily and almost hourly contact with her nurses, can readily estimate their qualifications, and at the end of two months' probation, and often before, will know whether the material is there that can be trained into a competent nurse."

* * *

"In laying out any hospital, the needs of the coming years should be considered, and whatever is built first should be built with reference to the completed whole . . . The entrance to the main building should be attractive and inviting. Make it look as cheerful and hopeful as you can."

The banana may be used either as a fruit or a vegetable. When partially ripe it should be considered as a starchy vegetable much like the potato and should be used only cooked. In the ripe state it is a sweet fruit and should be eaten raw. Bananas are rich in vitamins and minerals. They are valuable members of the diet.

Institutional Nursing

The Metric System and the Nurse

J. K. W. Ferguson, M.D., *and* R. B. Kerr, M.D.

Average reading time — 8 min. 24 sec.

In recent years the metric system has found increasing favor as the method of expressing weights and measures in medical practice. Nurses have long been familiar with its use in connection with the intravenous administration of fluids and also for the measurement of urinary output. More recently they have been accustomed to administering newer drugs such as the sulfonamides in metric units. The metric system is widely used in medical literature and recent medical graduates are being taught to prescribe even older drugs in metric dosage. Since all the new drugs are being prescribed in metric dosage forms it is only a matter of time till the metric system will replace the older systems of measurement. Consequently, it is of great importance that nurses become more familiar with the metric system.

The metric system has several advantages. In the first place its units are internationally accepted and uniform in all countries; this is of particular importance in Canada where we differ from our closest neighbors in the meaning of the fluid ounce, the pint, and the quart. Secondly, computations are much simpler, since all units are multiples of ten instead of such awkward figures as 437½ grains to the ounce in the Imperial system or 454.6 grains of water in the fluid ounce in the United States. Percentage solutions are more easily and accurately prepared in the metric system.

The metric units of weight most commonly used are the milligram, the gram, and the kilogram; 1000 milligrams make 1 gram and 1000 grams make 1 kilogram. The units of volume correspond to those for weight: one litre is the volume of 1 kilogram of water at 4°C.; one one-thousandth part of the litre is the millilitre or mil. This is also known as the cubic centimetre or cc. Consequently, one cc. is the volume of 1 gram of water at 4°C. The teaspoonful for medicinal purposes is usually considered to be equivalent to 4 cc. The teaspoon, as purchased for table use, may contain from 3.5 to 5 cc., but the kitchen measuring teaspoon usually contains 5 cc. For this reason, when accurate dosage of liquids is important, a good measuring graduate should be used. Many now in use are marked according to both metric and Imperial systems.

Prescriptions in the metric system are always written with Arabic numerals — that is, the common type of numeral rather than the Roman numeral. When drugs are ordered by weight, the dose may be expressed in grams or in milligrams. For example, an ordinary dose of phenobarbitone might be expressed as: 0.1 gram or as 100 milligrams. If the dose is larger than 0.1 gram it is usually considered advisable to express it in grams, but if it is smaller — for example, 0.06 grams — it is more convenient to say or write 60 milligrams. Doses of liquid preparations are usually ordered in cc., or if they are to be taken by the patient at home, they

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Dr. Ferguson is professor of pharmacology at the University of Toronto while Dr. Kerr is associate professor of medicine and head of the Department of Therapeutics at the same university.

may be ordered by the teaspoonful, or in other units of domestic measure. If prescriptions are written without stating units, the figures refer to grams if the material is a solid, and to cc. if the material is a liquid.

For example: Sodium bicarbonate 1.0 means 1 gm. but paraldehyde 8 means 8 cc. or 2 teaspoonsful. A prescription written according to this convention is shown as follows:

Ammonium chloride		0	6
Camphorated tincture of opium			
Syrup of Tolu	aa	1	0
Water to		4	0

Notice the vertical dash; this indicates the position of the decimal point, for either grams or cc.

Various abbreviations are used for the units of the metric system. The gram may be represented as follows — G. or gm. These abbreviations are peculiar to the medical uses of the metric system. Chemists would use a small g. as the abbreviation for the gram but this is too likely to be confused with the grain and is not used for medical purposes. Milligrams may be written as mg. or mgm. The usual abbreviation for the litre is l. and, as mentioned above, cc. or mil represent the same volume — namely, the cubic centimetre or millilitre.

Table of Approximate Equivalents for Weights and Measures for Dosage Purposes

Metric System	*Imperial System*
0.06 cc.	1 minim
0.6 cc.	10 minims
1 cc.	15 minims
4 cc.	1 drachm
30 cc.	1 ounce
100 cc.	3½ ounces
500 cc.	17½ ounces
1000 cc. — 1 litre	35 ounces
600 cc.	1 pint (20 ounces)
1200 cc.	1 quart (40 ounces)
Weights	
0.1 mg.	1/600 grain
0.25 mg.	1/240 grain-1/250 grain
0.3 mg.	1/200 grain
0.4 mg.	1/150 grain-1/160 grain
0.5 mg.	1/120 grain
0.6 mg.	1/100 grain
1 mg.	1/60 grain
2 mg.	1/30 grain
5 mg.	1/12 grain
6 mg.	1/10 grain
8 mg.	1/8 grain
10 mg.	1/6 grain
15 mg.	1/4 grain
20 mg.	1/3 grain
30 mg.	1/2 grain
60 mg.	1 grain
0.1 gm. or 100 mg.	1½ grains
0.12 gm. or 120 mg.	2 grains
0.3 gm.	5 grains
0.5 gm.	7½ grains
0.6 gm.	10 grains
1 gm.	15 grains
4 gm.	1 drachm (weight)
30 gm.	1 ounce (weight)

It is quite common already for drugs to be labelled according to both the metric and the older system and this practice is likely to increase, in which case it should not be difficult for a nurse to administer a drug ordered either in metric or old units. However, it may easily happen that a drug will be available on the ward in a package labelled only according to one system, while the order for it may be written according to the other system. Consequently, it is important for the nurse to become proficient in making conversions from one system to another. To do this she must be familiar with the approximate equivalents between the two systems. A few approximate equivalents can easily be remembered. These are:

15 grains	1 gram
1 grain	60 mg.
1 fluid drachm	4 cc.
1 fluid ounce	30 cc.

A more extensive list of approximate equivalents is shown in the table.

Note that these equivalents are for Imperial measures used in Canada. The U.S. fluid ounce is larger than the Imperial fluid ounce. The U.S. pint (16 fluid ounces) is approximately 500 cc. (473.16 cc.).

These differences should emphasize the desirability of changing to the metric system.

Grams for Grains

A. Dorothy Potts

Average reading time — 2 min. 6 sec.

The nurses in the hospitals of Toronto now speak in terms of grams, milligrams, cubic centimetres, litres—the metric system. Is it a strange vocabulary to you? You first heard of it at school and again during your "probie" days. Brush up on it if you plan to come to Toronto to nurse. Doctors will write "Mrs. Jones — Give morphine sulphate mg. 15" (not gr. ¼). Don't let it frighten you. It really is quite simple. You can find metric tables with their apothecary equivalents in any textbook of materia medica. Be forewarned and come prepared.

The metric system of weights and measures is used extensively in every civilized country in the world. Its main advantage is in being a decimal system in which the divisions are the ratio of tens, hence relatively simple to use. Besides this advantage is the fact that most pharmaceutical supply companies label their products in the metric system and manufacturers mark measuring equipment for dispensing medicines in the same scale.

A group of clinical supervisors in Toronto met to discuss problems which the change-over might involve. They checked drugs and solutions, and suggested that these be relabelled with strengths and dosages in the metric system with their apothecary equivalents.

For student nurses they advocated added instruction in theory in the classroom and close supervision on the wards. For graduate nurses (employed on staff) organized classes and quizzes should be held.

To facilitate learning and lessen the danger of error they suggested that placards be posted on medicine cupboards showing dosages commonly ordered in both metric and apothecary systems.

The best means of acquainting the ever-changing private duty group with metric equivalents was next considered. It was recommended that pamphlets be made available at

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Miss Potts (Moose Jaw General Hospital; B.Sc., Teachers College, Columbia University, 1947) is clinical supervisor in orthopedics at the Toronto General Hospital.

registries and hospitals. These pamphlets would contain a brief explanation of the metric system, a few simple rules for converting doses from one system to the other, and a table of equivalents. Each newcomer would be given a pamphlet to use as a guide.

So, armed with a sound educational program, aided by labels, placards, pamphlets, and above all the conscientious co-operation of every nurse, we have adopted the metric system of weights and measures in the Toronto hospitals.

Silver Nitrate versus Penicillin

The admonition of Alexander Pope to "be not the first by whom the new are tried, nor yet the last to lay the old aside" seems apropos to the ready acceptance at this time of penicillin over silver nitrate as the best prophylactic against possible infections of the eyes contracted by the newborn baby as it passes through the birth canal.

Of the infections occurring in the newborn infant, gonorrheal ophthalmia is perhaps the most damaging, and was formerly responsible for many cases of blindness. The general term *ophthalmia neonatorum* is now used to include all inflammations of the eye occurring within two weeks after birth.

Credé, an obstetrician of Leipzig, Germany, first introduced in 1881 the use of silver nitrate as a preventive against ophthalmia neonatorum. After cleansing the eyes with water, he instilled a single drop of 2 per cent silver nitrate into each eye of the newborn immediately after birth. This simple procedure proved so effective in saving the eyesight of infants that it soon became routine.

Certain objections to the use of silver nitrate have been reported. A common one, and perhaps the only real disadvantage, is the possibility of the concentration of the solution through evaporation of the water, unless the container is tightly stoppered. This has been overcome by the use of a 1 per cent silver nitrate solution supplied in wax ampoules.

Silver nitrate, although not claimed to be the perfect prophylactic against ophthalmia neonatorum, is entirely safe when used in a 1, or even 2 per cent solution, and is highly satisfactory as a prophylactic agent. It is readily available, requires but a single application, and is known through long experience to be effective.

The successful treatment of many cases of ophthalmia neonatorum with penicillin naturally led to consideration of its effectiveness as a prophylactic agent. Franklin* undertook to evaluate clinically the use of penicillin in the form of drops for prophylaxis against ophthalmia neonatorum and to compare it with silver nitrate as commonly used for this purpose. He used penicillin in the eyes of each newborn infant delivered at the John Gaston Hospital, Memphis, Tenn., over a period of four months; for comparison, silver nitrate was used for a three-month period. A total of 1,710 infants (961 infants after the use of penicillin and 749 infants after the use of silver nitrate) were studied in the nursery.

The conclusions drawn from the study by the author are: "Penicillin compares favorably with silver nitrate as a prophylactic agent; penicillin prophylaxis is to be preferred because danger of permanent injury to the eye is eliminated; an instillation is non-painful; ocular abnormalities are less frequent during the first days of life; the solution of penicillin need not be made fresh each day; deterioration does not produce noxious substances; an excess of the solution may be used if desired, and the penicillin solution may be used for both prophylaxis and treatment."

Promising as these conclusions appear, there are certain practical objections to the use of penicillin as a prophylactic agent. Solutions of penicillin require refrigeration, and must be made up fresh each week or they deteriorate to the point where they are of no value. At least three or four instillations of penicillin are required which necessitates the establishment of a routine procedure to ensure daily treatment of all infants, without exception. A more serious objection is the possible sensitization of the infant so that the drug cannot be used safely thereafter.

Until more conclusive studies prove that penicillin solution can be used in both home and hospital, effectively and safely, the silver nitrate procedure should not be abandoned.

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*Franklin, H. Charles: Prophylaxis Against Ophthalmia Neonatorum. *J. of the Amer. Med. Ass'n.* 134:1230-1235 (8-9-47).

— *The Quarterly Bulletin, M.L.I.C.*

Public Health Nursing

Nursing in Industry

THELMA D. GREEN

Average reading time — 12 min. 4 sec.

WHAT IS THE *purpose* of the medical and nursing program in industry? It is a combined effort of clinical and preventive medicine and essentially must be positive in nature. Therefore it combines the emergency out-patient department of a hospital and the work of the public health unit.

The *objective* is the maintenance and improvement of the health of the employees, and of their families, and thus of the community through the application of the measures of prevention which are practised. As a general rule systematic treatment is referred to the family physician.

DUTIES OF THE NURSE

These vary according to the plant, the degree of its management's education and interest in its nursing and medical program. The nurse's responsibility is to educate and interest management. This is not always the primrose path. The duties include:

1. *First aid care:*

In emergency accident and illness, especially the more serious cases—notify the physician, control bleeding, restore breathing, prevent shock, prevent infection. Do only the essentials until physician arrives.

Know that you know your first aid — review it yourself and practise it frequently.

Do you know what to do about hemorrhage? Shock? Do you know pressure points?

Do you know how to direct transportation of a patient suffering from a possible head injury? Injured spine? Punctured lung?

Can you put on a bandage that is comfortable, looks neat, and won't get caught in machinery? Can you put on a good sling?

2. *Assistance with medical examinations:* The nurse's assistance will greatly conserve the physician's time. The nurse's part of the examination should aid the physician in securing the workers' better understanding of:

(a) The value and use of the medical and nursing services provided by the plant.
(b) The value of the examination.
(c) Procedure of the examination.

Develop a pleasant, confident, efficient technique of interviewing. The following activities are frequently handled by the nurse:

(a) Scheduling of appointments.

(b) Interviewing the worker previous to the examination.

(c) Doing routine tests and explaining their significance—e.g., temperature, hemoglobin, urinalysis, weight and height, vision.

(d) Taking specimens for serological and other laboratory examinations and explaining their significance.

(e) Interpreting to the worker plant policies regarding health and welfare, and his responsibilities for co-operation—e.g., sick benefit or hospitalization plans carried by the plant payroll; sick time allowed; recreational and hobby or vocational activities.

(f) Making periodic inspections of plant, looking for symptoms and indications of occupational or other illness among personnel and seeking a knowledge of work involved.

(g) Making inspections and interviewing workers in connection with return-to-work permits.

In a large plant a technician may be employed to do many of the tests thus

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Miss Green is nursing supervisor in charge of the health service for employees of the Provincial Government of the Province of Ontario, Government Building, Toronto.

saving time (doctor's and nurse's) and money. If the volume of work is not sufficient for this the nurse should have specialized training in these techniques.

3. *Participation in the health education program* should include:

(a) Follow-up for correction of remediable conditions.

(b) Supervision and rehabilitation of workers with adverse health conditions.

(c) Maintenance of complete records showing care given for non-occupational conditions.

(d) Health teaching in the training program and throughout employment.

(e) Utilization of the community resources —private physicians—health and welfare agencies.

Health education may include: Individual teaching or formal classes in home nursing, first aid, budgeting, practical mental hygiene (hobbies, arts, crafts).

4. *Assistance with safety education and accident prevention:* The extent to which the nurse participates in this program will depend largely on the size of the plant. Where there is a well-organized safety department with a full-time safety officer, the nurse will have little responsibility, but should be a member of the safety committee. In the smaller plant the nurse should not be responsible for the whole planning or direction of the safety program, but should assist in the following activities:

(a) Proper placement of workers according to physical and mental fitness.

(b) Teaching and training course.

(c) Safety committee work.

(d) Record and report keeping.

(e) Individual instruction of workers regarding accident prevention.

(f) Visual education, movies, posters and printed material.

(g) Distribution and care of protective equipment.

5. *Assistance with plant sanitation:* Here again the nurse's participation depends largely on the size of the plant. In the large plant with a sanitary engineer, the nurse's responsibility may be limited to inspection of women's toilet, wash, rest and change room facilities. The nurse should show an active interest in all phases of plant environment that affect the health and morale of the worker. However, direct responsibility for the supervision of plant sanitation or safety should be delegated to the proper departments. In smaller plants the nurse may be entirely responsible.

In most plants the nurse inspects the cafeteria, and in some may give dietary advice, but as far as possible in large plants this should be handled by a trained dietitian with the nurse giving co-operation. In small plants the nurse will have a great deal of consulting work to do along normal needs in diet for health maintenance as well as diet in relation to illness.

6. *Participation in welfare activities:* In general the workers avail themselves of the opportunity to discuss their financial, marital, religious, and other home problems with the plant nurse. Many plants provide a special department to handle the worker welfare activities. In such plants the nurse refers the problem to that department for further action. Otherwise she may assume complete responsibility for welfare activities. The nurse's participation may include:

(a) Development of group sick benefits, hospitalization, and life insurance plans.

(b) Personal counselling with workers regarding welfare problems.

(c) Development of recreational program, hobbies, etc.

(d) Co-operation with local welfare agencies.

(e) Planning of cafeteria, lunchrooms, and canteen services.

7. *Home nursing service:* Reasons for making home visits are:

(a) To advise medical care if needed, to instruct families in giving adequate care, and to give health supervision.

(b) To determine eligibility for benefits.

(c) To ascertain causes of absence.

(d) To assist the worker with his special problems.

(e) Less frequently, to give nursing care to the ill or injured worker. This may be carried out by: The nurse, who gives first aid, etc., in the plant health centre; a full-time plant visiting nurse; the local visiting nurse association, such as V.O.N. or health department.

An attempt should be made to avoid duplication of service. The plan for visiting sick or injured workers in their homes should be developed to secure maximum benefits to the workers and to the plant. Employment of nurses for this service may be necessary where community resources are not available, or cannot be co-ordinated with company policy.

8. *Records and reports:* These are to the industrial nurse what bookkeeping is to the accountant. They make it possible for her to prove to management the desirability of, and the value derived from, industrial nursing service.

(a) Medical records should be strictly confidential except as interpretations of them are needed by management. These records in their bearing on the employee's job relationship should be interpreted for the employer's use by the physician, without divulging medical findings.

(b) All medical records should be kept in the medical department, accessible only to the medical staff, and available for use each time a worker presents himself for care.

(c) When the physical examinations of workers are made outside the plant, the records or copies thereof should be made available to the nurse.

(d) Clerical assistance may be provided in order that the nurse's time may be conserved and records adequate.

HER DIRECT RESPONSIBILITIES

Management expects:

(a) She will like people, be carefully observant, and show kindness.

(b) She will have a broad understanding of people.

(c) She will have an easy manner—professional yet friendly, spiced with a healthy self-assurance.

(d) She will be interested in her work—have sound clinical judgment and good technical skill, and a capacity for listening above the average.

(e) She will pay extreme attention to detail.

This sounds like an angel, doesn't it?

An industrial nurse is responsible for the orderliness, cleanliness, quietness, efficiency, and personalized attention to all visitors (patient and others) to the health centre. The plan to benefit all employees whether sick or well calls for long- as well as short-range planning.

The nurse is responsible for the nursing policies, procedures, and procurement of standing orders of the health centre.

The logical, time-saving management of all cases is also the nurses' responsibility.

She must set an example of good health — mental and physical — and also for taking a share of her community's responsibilities.

The nurse is responsible for screening cases to be seen by the physician and recording the data, briefly and accurately.

The nurse is responsible for records — often, the filing system, follow-up system, etc.

HEALTH EDUCATION

Why plan for a program of health education? The nurse should bear in mind the seven objectives of education:

A sound mind in a strong, healthy body.

A home life that is happy, unselfish, democratic.

The ability to read and write, to think, study, and to act.

The knowledge and skill needed to earn a good living.

The use of free time for worthwhile activities and pleasures.

An informed citizenship dedicated to the common good.

A fine spiritual character that is trusted and admired.

In planning any program remember it is impossible to do all that has to be done. Therefore, select the things for emphasis that are going to give the best overall result in service to all the workers, and to the company.

When should the program of health education be initiated? With the employees at time of employment as a part of the pre-placement examination or in the introductory program.

It is well to work through already organized groups of the older employees, preferably by invitation. The groups may be formed among:

Secondary school age or athletic society enthusiasts; women's, mothers' or parents', veterans' and service organizations; young married women and men.

Seasonal education on topical subjects would touch on such topics as:

(a) Colds (food, rest, clothing).

(b) Vacation, summer or winter, (clothing—prevention of accidents and sunburn—pure water and milk—swimming, etc.)

(c) Normal diets for summer and winter.

(d) Mental hygiene of a practical acceptable nature.

(e) Coal and wood furnaces (dangers to be avoided).

Special groups with personal defects will need instruction in relation to their problems. Such topics as: hard of hearing, eye conservation, posture, diabetics, rheumatics, tuberculosis. As the need arises or by observation or in response to requests or questions asked by workers, the nurse plans her health education talks.

Methods of health teachings:

1. The personal interview with the employee still remains the mainstay. It will assure the most successful results.
2. Pamphlets that are easily available, carefully selected, seasonal, interesting, colorful, simple and arresting.
3. Bulletin boards for up-to-date posters, clippings, etc.
4. Films and film-strips.
5. The plant paper is one of the best. Have a committee of workers assist you in the set-up. Be sure your material is authentic, appealing, brief, to the point, and approved.
6. Magazine and journal articles.
7. Open forum and discussion groups—round tables. Be sure of your chairman, your material, yourself, your group. Don't start anything you can't control but don't hesitate to try a new venture. Invite your community to share both as participants and audience. Invite the wives, husbands, children, family physicians, ministers, local medical officer of health, public health nurses, women's institute.
8. Radio talks.

STANDING ORDERS

Why are they necessary? The nurse has not a medical degree, therefore she should not assume responsibility for service outside the field of her professional training. Standing orders, signed by either her medical director, the plant physician, or the local medical society, are a guide and safeguard to her. General standing orders have been prepared by the Council on Industrial Health of the American Medical Association. These have been quite generally adopted by Canadian industry.

In procuring specific standing orders, think what you are treating each day, note the usual treatment, edit and formulate these systematically and then have your medical director, plant physician, or the local medical society go over them, add or delete as necessary, and sign.

Such orders cover the treatment of:

Colds, sore throats, headaches, sprains and strains, lacerations, abrasions, contusions, indigestion, pain in abdomen, menstrual cramps, etc.

Today there is no doubt that most business managements feel that increased production comes from provision for better employee health and safety needs. Management has a stake in better nutrition, in health, in medical and nursing education and care.

Red Cross Information Bulletin

Through the Canadian Red Cross Society, the League of Red Cross Societies is making available to Canadian nurses, at the subscription rate of $1.00 per year, the publication entitled *Information Bulletin for Red Cross Nurses*. The *Bulletin* appears in English, French, German, and Spanish. This publication, issued quarterly, carries articles designed for nurses serving in the Red Cross, but is also of interest to all nurses throughout the world as a means of sharing information on an international basis.

Those desiring to subscribe should do so by writing to: **Nursing Department, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.**

Aux Infirmières Canadiennes-Françaises

L'Enseignement Clinique

SOEUR M. C. MARCIL, S.G.M.

Average reading time — 9 min. 36 sec.

DANS LE BUT de donner à nos étudiantes l'expérience pratique en rapport avec la théorie reçue à l'école, nous nous préparons à organiser l'enseignement clinique dans les quatre grands services de l'hôpital, soit: médecine, chirurgie, pédiatrie, obstétrique.

Depuis longtemps, chaque hospitalière a compris l'importance de l'enseignement clinique et tente de le réaliser. Etant donné les multiples obligations concernant l'administration de son département, les activités des services et les exigences actuelles, nous croyons que le temps dont elle peut disposer est insuffisant en comparaison des besoins de l'élève pour sa formation professionnelle. En conséquence, nous voulons organiser l'enseignement clinique avec des infirmières spécialisées en la matière qui travailleront, en co-opération avec l'hospitalière du service. Depuis septembre, nous avons réalisé notre projet en obstétrique et déjà nous avons constaté tous les avantages de cette méthode d'enseignement pratique.

SOMMAIRE DE NOTRE ORGANISATION

Nous avons formé un comité composé des membres suivants: la directrice des infirmières, la directrice du programme d'éducation, les hospitalières du service, et l'institutrice en enseignement clinique.

A l'occasion de la réunion mensuelle, chaque membre émet ses idées, fait part de son expérience, et le tout est discuté entre les membres du personnel de l'école et ceux du service d'obstétrique. De cette façon, la relation qui doit exister entre l'école et l'hôpital est constante.

L'infirmière institutrice, préposée à l'enseignement clinique, a été préparée en vue du rôle à remplir. Elle est entièrement à la disposition des étudiantes au cours de la journée—leur donne l'enseignement pratique, les dirige dans leur travail, et se charge aussi de leur surveillance.

LES AVANTAGES

Avantages que l'enseignement clinique semble apporter à nos étudiantes:

1. *L'enseignement clinique établit la corrélation qui doit exister entre la théorie et la pratique:* L'étudiante reçoit l'enseignement théorique au cours des mois qui précèdent son stage en obstétrique et, pour plusieurs, l'enseignement est donné pendant la durée du stage. L'enseignement clinique vient compléter et appliquer les notions que l'étudiante reçoit à l'école.

2. *Le fait de la présence continuelle de l'institutrice* avec les étudiantes est un facteur contribuant à la formation intégrale de l'infirmière.

3. *L'application du plan de roulement* est une garantie d'un stage bien équilibré selon l'expérience antérieure de l'étudiante. A son arrivée dans le service, l'étudiante est placée en salle publique, auprès des parturientes. Après quinze jours de service, elle est dirigée en chambres semi-privées pour quinze autres jours, puis en chambres privées pour le même temps. Elle se rend ensuite à la salle d'accouchement pour deux semaines. De là, elle est préposée au laboratoire des boires pour une semaine; ensuite, elle fait une semaine à titre de suppléante, termine le service de jour par un stage d'une semaine à la pouponnière.

Soeur Marcil est directrice des infirmières de l'Hôpital Notre-Dame en Montréal.

Elle commence ensuite le service de nuit par une période de trois semaines et le stage qui a duré quatorze semaines est terminé.

4. *Le plan d'orientation individuelle:* Il est une source d'économie, d'énergie, et de temps pour l'étudiante. Dès son arrivée dans le service, l'étudiante est initiée à la routine du département.

5. *Les différentes méthodes employées en enseignement clinique* permettent de tirer le meilleur avantage possible de toutes les ressources éducationnelles du département:

(a) *La conférence du matin:* Le rapport de nuit renseigne le service de jour et les observations de l'hospitalière permettent d'organiser un plan de travail pour la journée.

(b) *Les démonstrations* permettent l'application de la technique et assurent de meilleurs soins aux malades.

(c) *La clinique au lit du malade* cultive l'esprit d'observation et exerce l'étudiante à reconnaître les symptômes avec le traitement qu'ils requièrent. Elle contribue par le fait même à sa formation professionnelle.

(d) *Les rapports de cas* font bénéficier toutes les étudiantes de l'expérience d'une en particulier. Quand une étudiante prend soin d'un cas qui présente quelque particularité intéressante, avec l'aide de l'institutrice, l'élève prépare un rapport dont elle fera bénéficier ses compagnes à l'occasion de la conférence du matin. Elle raconte l'histoire du malade, les symptômes qu'elle présente, le diagnostic du médecin, le traitement appliqué, et le résultat obtenu. Le tout se fait dans une ambiance de discrétion professionnelle.

(e) *Les études de cas* stimule l'esprit d'observation, oblige l'élève à faire des recherches, et par le fait même lui donne des connaissances nouvelles.

(f) *L'enseignement individuel* permet un enseignement adapté aux besoins de chacune. Du fait de sa présence continuelle dans le service, l'institutrice initie l'élève à la routine du département, l'entraîne aux techniques particulières à l'obstétrique, la dirige dans son travail, l'observe, répond à ses questions, et corrige chez elle ce qui serait en déficience.

(g) *Le plan de surveillance* est une garantie de formation intégrale et permet un contrôle des aptitudes et de la valeur professionnelle de chaque étudiante.

(h) *Le bulletin mensuel* est un stimulant pour l'étudiante.

(i) *Le rapport des cas traités,* documents précieux pour le dossier de l'élève, est rempli chaque matin en présence de l'institutrice en enseignement clinique.

(j) *L'examen pratique* est un complément de l'examen théorique, permettant de juger de la valeur de l'étudiante au point de vue pratique.

(k) *La fiche personnelle:* L'institutrice remplit une fiche pour chaque étudiante. Cette fiche nous indique l'évolution du stage, le nombre d'heures d'enseignement clinique reçues, fait mention des études et rapports de cas de même que du résultat de l'examen pratique.

Une fois le stage terminé, cette fiche est apportée à la directrice des infirmières qui en prend connaissance et la place ensuite au dossier personnel de l'étudiante.

Nous sommes certaines que nos étudiantes apprécient cet enseignement en obstétrique. Depuis un mois, nous réalisons le même programme en pédiatrie; là, comme en obstétrique, nos élèves se sentent comprises et aidées. C'est en toute confiance qu'elles poursuivent leur stage dans ces services et nous sommes convaincues que leur expérience est complète tant au point de vue pratique que théorique.

Aid in VD Control

The Philippine Republic is one of several countries granted WHO's help in the field of venereal disease during the last few months. Recently Dr. Alain Spillmann (France) made a one-month trip to Italy as WHO's expert consultant to study the VD situation and to help establish demonstration programs in several cities. Such a plan is already in operation in Naples with excellent results.

Czechoslovakia also has requested technical assistance from WHO in developing anti-VD plans. Dr. James Lade (U.S.A.) has been assigned by the World Health Organization to assist local authorities there.

— *WHO Newsletter*

Trends in Nursing

Average reading time — 11 min. 12 sec.

WHO and Nursing

Perhaps many Canadian nurses are asking the questions raised by Dr. Neville Goodman in his article appearing in the March number of the *American Journal of Nursing*. Is the World Health Organization concerned with nursing? Are nurses participating in its work? What does it plan to do for nursing in the future?

To answer these questions in brief, today WHO Field Services Division has a total of two nurses in China, two in Ethiopia, and one in Greece. What can so few do among so many? The main service rendered by these nurses is to assist "the local authorities in building personnel training programs" and "in improving the economic and social status of the nursing profession." "The services of a single good nurse acting as adviser and nursing consultant in a WHO field mission can go a long way."

In Ethiopia, with a population of around twelve million and only one Ethiopian physician and one Ethiopian nurse, conditions are such that the two or three nurses working under WHO have had to undertake basic training of so-called "dressers" or male nurses and teach them the fundamentals of sickroom care.

In China the two nurses now with WHO are concerned almost entirely with consultations on problems of public health nursing and nursing education and in helping combat the principal communicable diseases: plague, tuberculosis, cholera, etc.

The one nurse in Greece has had to confine her activities almost entirely to tuberculosis. Two three-month training courses in tuberculosis nursing and the installation of x-ray apparatus in hospitals and clinics have been included in the program. Through the efforts of Hélène Nussbaum, a Swiss nurse, a nurse has been appointed to the Ministry of Health and a nursing law has been enacted.

Under the fellowship program there have been sixteen grants to nurses for advanced study in education methods, public health nursing, social welfare, midwifery, maternal hygiene, etc.

WHO, now that it has become a permanent specialized agency of United Nations, will need to expand the nursing program and to recruit specialists to work with the WHO demonstration team. Nurses are assured that the importance of nursing in raising the level of health of all peoples — WHO's objective — is recognized and that the Interim Commission "deeply appreciates the enthusiasm and devotion" of nurses to the attainment of WHO's objective.

Our Public

In the January number of our *Journal*, the general secretary of the Canadian Nurses' Association spoke to Canadian nurses on farm forums. Since that time I am sure you cannot have helped noticing the number of articles appearing in the press on the activities of the farm forums.

Did I hear you ask who are the members of the farm forums? They are men and women from all walks of life — the men and women who in a democratic society influence the thinking of the people in their community.

What are the farm forums talking about? Among other things they are talking about health — how to keep well, how to secure medical care when ill, the types of medical and nursing care their families need. Are they always well informed on such questions?

The following quotation from *The Canadian*, Carleton Place, Ontario, January 20, 1949, may help to answer this question: "The meeting supported the members of — Farm Forum, — County, in asking the use of the smaller local hospitals as training schools for nurses, to make training facilities more readily available to rural girls."

Can nurses afford to ignore the demands of these very active groups? Are we making it our immediate task to inform these thinking people on nursing? Are local nursing organizations asking for an opportunity to present the facts about nursing to these public-spirited citizens?

A Challenge

Janet Geister in February *R.N.* voices a challenge to American nurses. Have you ever heard something like this before? — "The average nurse's participation is essential both within and outside the profession. You are the average nurse. You are our most potent interpreter to the public, for your daily work is with people — people of every circumstance." Miss Geister then makes the following statement:

> The greatest single need before us today is a well-informed profession. We know there are shortages . . . but too many of us are unaware of . . . our own attitudes toward these things.

Awareness is then defined and the article, after paying tribute to Dr. Brown's report, closes with these words: "The future of nursing cannot lie in a book — it lies in the heart of the average nurse."

Progress Report on Job Analysis

Interest in Job Analysis runs high. We know, because we have sold 245 copies of "Job Analysis and Job Evaluation" compiled by the Committee on Institutional Nursing, Canadian Nurses' Association. Sixty-five of these 245 copies have been sold to nursing schools and universities in the United States.

We thought, therefore, that you might be interested in a brief summary of the report by Mr. H. A. Goddard, Director of Enquiry, Hospital Job Analysis, The Nuffield Provincial Trust, *Nursing Times*, January 29, 1949. To offset any unfavorable reaction to the methods used, which are methods borrowed from industry, Mr. Goddard defines industry as the quality of showing zealous application to one's work and pays the employees of the health services the compliment of being most zealous in application to duty. He further defines job analysis as:

> The scientific study and statement of all the facts about a job which reveal its content and the modifying factors which surround it. In other words, it is a full and accurate statement of what a person essentially does and what qualities he or she must have to do it.

In the March number of *The Canadian Nurse*, we made a brief digest from *Nursing Times* on the methods employed to secure the facts. The next step, interpreting the facts, is still to be done. Miss M. E. Johnston, formerly secretary to the Public Health Section, has been appointed by the Trust as administrative assistant charged with the conduct of Job Analysis. We hope to be able to bring you the results of this analysis at an early date.

News from South Africa

South Africa also has its nursing shortage and is considering the possibility of expanding training facilities. A report of a survey by the National Executive Committee of the National War Memorial Health Foundation shows that the biggest problem is the provision of nurses for the non-European community. The reasons given for the shortage are: attraction of jobs with more pay and less work; wastage of nurses in training which is 53 per cent; lack of secondary school education for non-European girls.

Why Use Films?

The following paragraphs are excerpts from a National League of Nursing Education bulletin on this topic:

> The student nurse of today will be the health teacher of tomorrow . . . will be called

upon to show patients and their families how to manage the problems of illness . . . will be looked to as a source of health instruction in her community. As such she should be familiar with the techniques used in out-of-classroom teaching . . . will have to know how to use the newer devices for the enrichment of teaching.

How much easier it will be for this nurse-teacher of 1950 or 1955 or 1960 if she has been "brought up" with films . . . if, as a nurse-student, she herself has been taught with them.

Getting acquainted with films: Your film committee, once it gets started, may want to do more than list films and their sources. It may wish to make evaluations of films for its catalog . . . determine just how useful a film is for a specific purpose . . . what points in it the instructor should highlight . . . what points should be corrected.

Helpful as evaluations are, however, reading about a film will never take the place of seeing it. Film committees should help make arrangements for instructors to preview films before using them with students. Whenever a particularly good film comes to your attention, why not have it shown at a meeting? Or you might arrange to have suitable films shown in connection with any institutes which your association may be sponsoring. Above all, encourage discussion of the films which you show. You will get many good ideas from these discussions . . . and so will your audiences.

The film is a comparatively new educational tool. As educators, it behooves us to know *what* films there are, *where* we can get them, and *how* to use them.

New Publication

Canadian Institute of International Affairs is publishing a new pamphlet *The People's Health.* In it, Canada's health problems and the world health problems are discussed. Part One by C. Fred Bosworth, well-known Canadian journalist, discusses the aims and provisions of Canada's new health program. Part Two by Dr. Brock Chisholm discusses WHO — its origins, its plans for the future, what it has achieved to date, and the importance of its work. Price 15 cents or 10 cents for fifty or more — National Secretary, 230 Bloor St. W., Toronto 5.

Last Call for Stockholm!

Are you booked for Sweden this summer for the International Council of Nurses Conference? Or are you still considering whether or not to go? If you are booked, well and good and, incidentally, "Bon Voyage." But if you have yet to make your reservation, beware, for the bird of Time is on the wing, and by the time this appears in print he will be gliding in under quarter throttle for a landing, and if you want to go then, you will have to look very smart, indeed, or you will literally miss the boat.

All nurses registered for C.N.A. Official Tours will automatically receive a copy of the Illustrated Tour Programme, but anyone who is going to the Conference is welcome to a copy. All you have to do is drop a line to Thos. Cook & Son Ltd., 1241 Peel St., Montreal 2, and they will be very pleased to send you a copy. You will find it invaluable.

Canada is going to be well represented at the Conference, and that is as it should be. Mr. R. F. Cummings, the Montreal manager of Thos. Cook & Son Ltd., who, as you all know by now, is handling our Travel Arrangements, tells us that he has completed the arrangements of a strong contingent who are all set to leave with the first party on the *Empress of France* on May 13, and he is now finalizing the plans of those who are going over with the "second wave" on the next trip of the *Empress of Canada* on May 27. At this moment, there are a very few berths left in both the tourist and first class for these two sailings but, against that, there are new, if somewhat belated, inquiries coming into Cook's almost daily, which will absorb the few remaining vacancies well before sailing date. Nevertheless, even though you have left it so late, you can still send in

your application. After all, when you are dealing with large numbers, it is almost inevitable that someone will be forced to drop out at the last moment, due to unforeseen circumstances. But this is not an invitation to delay further in the belief that you will be able to get a cancellation at the last moment. There are only a limited number of berths allotted to Cook's for nurses going to the Conference and, when those berths have been filled, there is not a hope of getting any more. If you have not *quite* made up your mind, remember, this is positively "the third and last time of asking!!"

Orientation et Tendances en Nursing

L'O.M.S. ET LE NURSING

Dans *l'American Journal of Nursing*, le Dr. Neville Goodman répond à des questions que des infirmières se sont bien souvent posées. L'Organisation Mondiale de la Santé s'occupe t'elle des infirmières? Les infirmières participent-elles au travail de cette organisation? Quels sont les projets de l'O.M.S. pour les infirmières?

Voici en résumé la réponse de l'O.M.S.: La division du service compte deux infirmières en Chine, deux en Ethiopie, et une en Grèce. C'est peu en comparaison du travail qu'il y a à accomplir. Le travail de ces infirmières consiste à aider les autorités locales dans la préparation du personnel par des programmes d'études appropriés et à améliorer les conditions professionnelles et économiques de l'infirmière. Les services que peut rendre une seule infirmière comme consultant sont incalculables.

En Ethiopie, la population est d'environ douze millions et ne compte qu'un médecin et une infirmière éthiopiens. Les deux infirmières travaillent sous les auspices de l'O.M.S. et doivent enseigner à des ambulanciers quelques principes fondamentaux du soin aux malades. En Chine, les deux infirmières de l'O.M.S. s'occupent des problèmes d'hygiène publique, de la formation des infirmières, et à combattre les maladies contagieuses, tel que: la peste, la tuberculose, et le choléra, etc. L'infirmière en Grèce ne s'occupe que du problème de la tuberculose. Deux cours, chacun de trois mois, en tuberculose a été organisé pour les infirmières. L'installation de rayon-X dans les hôpitaux et dans les cliniques sont au programme. Grâce aux efforts d'une infirmière suissesse, Mlle Hélène Nussbaum, une infirmière a été nommée au Ministère de la Santé et une loi concernant les infirmières a été sanctionnée.

L'O.M.S. a donné seize bourses d'étude à des infirmières, afin de leur permettre de poursuivre des études supérieures sur les méthodes d'éducation en hygiène publique, en bien-être social, en hygiène maternelle, et comme sages-femmes.

Maintenant que l'O.M.S. est reconnu comme organisme permanent des Nations Unies, le travail des infirmières va prendre plus d'importance et il va falloir recruter des spécialistes pour travailler dans l'équipe chargée des démonstrations. Les infirmières sont convaincues de l'importance du nursing pour atteindre le but de l'O.M.S., à savoir: "Elever le standard de santé de tout le monde." On reconnaît que le dévouement et l'enthousiasme des infirmières sont d'une grande valeur pour atteindre ce but.

PROGRAMME DE FARM FORUM

Dans le numéro de janvier de notre *Journal*, la secrétaire de l'Association des Infirmières du Canada nous a parlé d'un programme radio diffusé à la population rurale, intitulé: Farm Forum. Depuis que ce programme nous a été signalé, les infirmières ont été lire dans les journaux les articles commentant ce programme. Vous vous demandez peut-être qui dirige ce programme? Ce sont des hommes et des femmes de tous les degrés de l'échelle sociale, dont l'esprit vraiment démocratique exerce une influence sur la façon de penser de leur entourage.

De quoi parle t'on à ce programme? Entre autre chose, l'on parle de la santé, comment vivre en bonne santé, comment se procurer des soins médicaux en maladie, les besoins de la population rurale en ce qui concerne les médecins et les infirmières.

Lors d'un forum, l'on en vint à la conclusion suivante: Que dans les petits hôpitaux ruraux, il devrait y avoir des écoles d'infirmières; celà favoriserait les jeunes filles des campagnes. L'auditoire présent se montra en faveur de cette recommandation.

Les infirmières peuvent-elles ignorer les demandes de ces groupes bien pensants et si actifs? Les renseignons-nous suffisamment sur les activités des infirmières?

UN DÉFI

Un défi a été lancé aux infirmières américaines. Il faut que la masse des infirmières soient renseignées sur les activités de la profession, afin d'être en mesure de renseigner le publique sur les questions touchant les infirmières. Vous faites partie de la masse des infirmières, donc vous êtes la personne sur laquelle l'on peut le plus compter pour renseigner le publique.

La chose la plus nécessaire actuellement est que les membres de notre profession soient bien renseignées. L'on sait qu'il manque des infirmières, etc., mais ce que le publique ne sait pas, c'est l'attitude des infirmières sur ces sujets. A la fin de son rapport sur la situation du nursing, le Dr. Brown termine son livre par ces mots: "Si vous vous demandez quel sera l'avenir des infirmières, ne cherchez pas la réponse dans un livre — la réponse vous la trouverez dans le coeur de l'infirmière."

RAPPORT SUR L'ANALYSE DU TRAVAIL

L'on s'intéresse vivement à l'analyse des tâches. Comme preuve à l'appui, nous pouvons nous dire que nous avons vendu 245 exemplaires de l'Analyse du Travail et de Son Evaluation. Soixante-cinq de ces exemplaires ont été vendus à des écoles d'infirmières et à des universités aux Etats-Unis.

Les infirmiéres intéressées dans l'analyse du travail et dans son évaluation pourront relire avec intérêt le numéro de mars du *Canadian Nurse*, dans lequel l'on parle de l'analyse du travail qui se fait actuellement en Angleterre.

NOUVELLES DE L'AFRIQUE DU SUD

En Afrique du Sud, il manque aussi des infirmières. Une enquête faite par le comité exécutif de la National War Memorial Health Foundation montre que le plus grand de nos problèmes est de trouver des infirmières pour la population non-européenne. Les raisons pour lesquelles il n'y a pas de jeunes filles indigènes dans la carrière d'infirmière sont les suivantes: Elles sont attirées vers des carrières où elles sont mieux rémunérées, tout en travaillant moins; la perte occasionnée par les jeunes filles, qui ne terminent pas leur cours (53 pour cent); et le manque d'écoles primaires supérieures pour les jeunes filles indigènes.

POURQUOI EMPLOYER LE CINEMA?

Nous lisons dans le bulletin de la National League of Nursing Education: L'élève-infirmière d'aujourd'hui enseignera demain comment vivre en bonne santé. Elle est appelée à enseigner à ses malades, à des familles, comment se tirer d'affaire en cas de maladie. Elle sera consultée dans son milieu sur les questions de santé. Elle enseignera comme elle a été enseignée à l'école. Si durant son cours l'on s'est servi des découvertes modernes, ce sera tout à son avantage.

Il sera beaucoup plus facile pour une infirmière d'enseigner en 1950, 1955, et 1960, si durant son cours l'on s'est servi du cinéma.

COMITÉ DU CINEMA

Une fois le comité formé, les membres peuvent y prendre un grand intérêt. En plus, de faire la liste des films, ils peuvent en faire l'évaluation, déterminer l'utilité du film pour tel but bien défini, les points sur lesquels l'institutrice devraient appuyer, les points à corriger. Lire l'évaluation d'un film peut être utile, mais il n'y a rien comme de le voir.

Dans une réunion d'institutrices, il serait bon de mettre un film au programme comme moyen d'enseignement; l'on pourrait étudier comment l'employer, où se procurer les films, etc.

Character tells in the long run, and many are the instances of the failure of skill and knowledge through the persistence of a bad habit, through untrustworthiness or lack of stamina. No doubt the immoral often seem to succeed when they meet the moral; but all serious students of human nature would give a higher place in the scale of ultimate values to character than to simple intellectual brilliance. — HENRY HODGKIN

The peculiarity of ill-temper is that it is the vice of the virtuous. It is often the one blot on an otherwise noble character. You know men who are all but perfect, and women who would be entirely perfect, but for an easily ruffled, quick-tempered, or "touchy" disposition. This compatibility of ill-temper with high moral character is one of the strangest and saddest problems of ethics.

— HENRY DRUMMOND

Nursing Profiles

E. A. Electa MacLennan has accepted the position of director of the new school of nursing that is to be opened at Dalhousie University, Halifax, this year. The need for a university school, where both graduate and undergraduate courses will be given, has long been recognized in the Maritimes. We extend our best wishes for the success of this development.

Miss MacLennan, a Maritimer by birth, graduated in Arts from Dalhousie University before entering the school of nursing of the Royal Victoria Hospital, Montreal. Following her professional training, she enrolled in the McGill School for Graduate Nurses, receiving her certificate in teaching and supervision in schools of nursing in 1933. For two years she was on the staff of the Victorian Order of Nurses in Montreal, going to the Vancouver General Hospital as clinical instructor and junior administrator in 1935. She returned to the V.O.N. in 1937, first as staff nurse then, two years later, as National Office supervisor. In 1940 she went to Columbia University where she secured her Master of Arts degree in 1941, specializing in supervision in public health nursing. She returned to the V.O.N. and, until the end of 1943, was supervisor in the Eastern Canada area.

The expansion of the activities of the National Office of the Canadian Nurses' Association attracted Miss MacLennan to an assistant secretaryship in 1944, where her particular responsibility was the publicity work of the association, in which she was notably successful. When the federal grants to nursing were discontinued in 1946, she joined the faculty of the McGill School for Graduate Nurses as assistant director and assistant professor in public health nursing.

Garcia, Montreal

ELECTA MACLENNAN

This breadth of experience has fitted Miss MacLennan admirably for the new post she is to occupy. Her knowledge of and practical experience in professional activities will make her a very valuable addition to the nursing association in Nova Scotia. We shall watch the progress of this new school under Miss MacLennan's direction with great interest.

Dorothy Mickleborough has assumed her duties as assistant superintendent of the Victorian Order of Nurses for Canada, with headquarters in Ottawa. Born in St. Thomas, Ont., Miss Mickleborough graduated in 1918 from the Seattle General Hospital. After a brief period of service with the American Army Nurse Corps at the close of World War I, she became supervisor of surgery in her home school of nursing. From 1921 to 1925 she was operating-room supervisor and assistant superintendent at the Vernon (B.C.) Jubilee Hospital. After obtaining her certificate in public health nursing from the University of Toronto, Miss Mickleborough joined the staff of the Ontario Department of Health as a staff nurse for two years and as a supervisor for five years. In 1934 she began her long association with the V.O.N. as a National Office supervisor. For an interim period last autumn she served as acting chief superintendent. Miss Mickleborough was chairman of District 5, R.N.A.O., for several years and also served as convener of the Public Health Section, R.N.A.O., for some time.

Christina MacCullie was named superintendent of nurses at the Medicine Hat General Hospital early this year. Born in Walkerton, Ont., Miss MacCullie organized the school of nursing in the Kenora General Hospital where she had served as superintendent of nurses for fourteen years. She has had considerable experience along administrative lines in other hospitals also.

Dora Wilson Miller has retired from the staff of the Homoeopathic Hospital, Montreal, completing thirty-five years of faithful service. Born and educated in Montreal, Miss Miller graduated from the Phillips Training School for Nurses of the Homoeopathic Hospital in 1912. In 1914 she became night superintendent there and served successively as head nurse, charge nurse of the operating-room, and assistant superintendent before she was named lady superintendent in 1935.

Numerous social events were held on the occasion of Miss Miller's retirement when she was the recipient of many beautiful gifts. Miss Miller will reside in Montreal.

Assoc. Screen News, Montreal

DORA MILLER

One of the first nurses in Nelson, B.C., was **Caroline (Kennedy) Watts.** She has recently celebrated her eighty-eighth birthday. Born in St. Andrews, Man., it was always Mrs. Watts's girlhood ambition to become a nurse. She graduated from the Winnipeg General Hospital and engaged in private duty nursing in various western communities. At that time Mrs. Watts recalls the average monthly pay for the private duty nurse was $40 with $3.00 extra if she nursed a typhoid case! In 1898 she became matron of the Nelson Hospital and, though she married the following year, she kept on with her nursing activities until she retired at the age of sixty. All through the years Mrs. Watts has maintained a keen and lively interest in the activities of the nursing profession.

In Memoriam

Gertrude E. Badke, a graduate of the Guelph General Hospital, died on January 31, 1949, in her forty-eighth year. Miss Badke was on the staff at Freeport Sanatorium, Kitchener, for fourteen years before becoming a floor supervisor at St. Mary's Hospital, Kitchener.

* * *

Jean J. Black died unexpectedly at her home in Gladmar, Sask., on January 10, 1949, at the age of eighty-three. Affectionately known as "auntie" to all the district, Miss Black had nursed in Toronto and Gravenhurst, Ont., before retiring some twenty years ago.

* * *

Alice G. (Gregory) Chesser, who graduated from the Royal Victoria Hospital, Montreal, in 1924, died at her home in Trail, B.C., on November 5, 1948, after an illness of several months. Mrs. Chesser had been superintendent of the Trail-Tadanac Hospital prior to her marriage in 1930 and was an active member of the local chapter of the R.N.A.B.C.

* * *

Nellie Dwyer, who graduated from St. Michael's Hospital, Toronto, in 1916, died on January 26, 1949, after an illness of ten months. Miss Dwyer had been active in nursing until she became ill and endeared herself to a host of friends and neighbors by her kindliness and generosity, her brightness and cheerfulness.

* * *

Mrs. Agnes R. Fewings, who graduated from the Medicine Hat General Hospital in 1901 and was married shortly after, died recently in Medicine Hat in her seventy-second year.

* * *

Anne D. McLeod, who graduated from

St. Boniface Hospital in 1902, died in Kamloops, B.C., on February 24, 1949, at the age of seventy-nine. During World War I, Mrs. McLeod was matron at Camp Shilo before going overseas in 1916. She had the distinction of being the first mother to accompany her son overseas on the same troop transport during that war. After returning to Canada she worked with the Department of Veterans Affairs in Ottawa until 1924, when she was transferred to Deer Lodge Hospital in Winnipeg. There she served as a nursing sister until her retirement in 1938.

* * *

Frances (Pat) O'Connor, who graduated from Hotel Dieu Hospital, Kingston, in 1942, died there on February 7, 1949, following a brief illness. Miss O'Connor enlisted with the R.C.A.M.C. shortly after graduation and, after eighteen months at Rideau Military Hospital, she served with No. 8 C.G.H. in Europe. She had been with the D.V.A. hospitals in different parts of Canada until the time of her illness.

Ann Elizabeth Parker died on February 17, 1949, in London, Ont., at the age of seventy-five. Miss Parker had engaged in nursing in Brandon and London for thirty years before retiring in 1939.

* * *

Barbara Paterson, a graduate of the Cornwall General Hospital, died in Montreal on February 10, 1949, at the age of forty-three.

* * *

Helene M. (Snell) Reynolds, who graduated from the Toronto General Hospital in 1916, died in Toronto on February 6, 1949.

* * *

Helen G. Shattuck, who graduated from the Royal Victoria Hospital, Montreal, in 1899, died in Ottawa on February 12, 1949, in her eighty-third year.

* * *

Vera (Nelson) Turnross, who graduated from the Queen Victoria Hospital, Revelstoke, B.C., in 1920, died there on January 29, 1949, at the age of fifty-three.

A Travelling Clinic

(*Continued from page 356*)

Also reached from the corridor is the kitchen with its sink and hot and cold running water, a drop table, locker, and a large size refrigerator. Completing the equipment there is a coal range, a two-burner gas stove, and an electric hot-plate.

The corridor next leads into the combination living- and dining-room. Furnished with lounge chairs, tables, and sofa, the ceiling is cream colored and the walls are buff. Yellow curtains and a russet carpet finish the decorative scheme.

A double heating system is incorporated in the car. One system uses hot water and is connected to a coil in the jacket of a coal-burning Baker heater. The other system uses a smaller tube, located inside the hot water pipe, and is connected to a steam outlet. Steam passing through this pipe heats the water in the circulatory system.

A two-way electrical system provides the power for lighting and other uses. While in transport, a series of batteries provide 32 volts D.C. current for lighting purposes. When parked, the power supply is connected to an outside source which provides 110 volts A.C. current for such electrical equipment as radio, razor, and other instruments. A second connection with the A.C. outlet feeds the current to a transformer which converts it to 32 volts D.C. for lighting. This method eliminates duplicate lighting systems.

The medical cars are part of the company's policy of preventive medicine. Apart from the clinics and medical service available to all employees, the Canadian National Railways requires all running tradesmen, including train and yard crews, to have a periodic physical examination. It was for this purpose the medical cars came into being in 1936. They brought the service to all such employees along the company's lines in Canada and the United States.

The service began with three cars and the fourth was added two years ago. The new car replaces an earlier one. Since the inauguration, the cars have completed four circuits of their respective territories and have a combined mileage of more than a hundred thousand miles. Each car takes about two years to complete a single circuit. During the war the service was curtailed somewhat due to a wartime shortage of doctors.

Student Nurses

Pemphigus

CHRISTINE FINES

Average reading time — 11 min. 12 sec.

PEMPHIGUS is a disease involving the skin. It can be acute or chronic. Practically nothing is known about its course or pathology. It is thought to be due to a virulent infection — probably with a virus.

It is characterized by large, relapsing, bullous eruptions of the skin and mucous membranes. These slough off leaving large raw spreading sores which do not heal. Sometimes the exudate dries on these oozing surfaces forming thick crusts, beneath which purulent fluid collects. It is characterized by an offensive, fetid odor which is often diagnostic.

This condition may occur at any age although it is more common in the forty to sixty years age group. It has not definitely been established yet whether this disease is contagious — some doctors believe it is. Most cases terminate fatally in a few weeks or months. Penicillin or sulfa drugs have no effect.

HISTORY

Mrs. M had been comparatively free from illness all her life. She was subject to "allergic rhinitis" during the winter season, but had had no "hives" recently. She lived on a farm where she came in contact with a lot of dust. She was married and the mother of four children. Two of her daughters had recovered from poliomyelitis.

Mrs. M was in her usual state of good health until she developed a cold-sore-like lesion on her lip. This lesion was non-healing and continued to spread and develop crusts. One month later she noticed a small, red, raised area in her left axilla. Soon this ruptured and a purulent fluid drained out. Then a crust formed, which, on falling off, left exposed a large raw area. This eruption under her left arm continued to spread leaving similar raw areas in its wake. More lesions developed on her breasts, chest, abdomen, thighs, and back. An investigation at the cancer clinic in Regina disclosed that the eruptions were non-malignant. Other lesions developed in her mouth leaving raw surfaces. She also complained of a sore throat, which made eating and swallowing very difficult.

Ten days prior to her admission to hospital, she developed large vesicles all over her body. These broke with a thin yellowish fluid escaping. There was a constant oozing of blood and serum from the raw areas, resulting in considerable loss of body protein. Eventually her whole body, with exception of the palms of her hands and soles of her feet, became involved with these non-healing lesions.

COMPLICATIONS

Malnutrition may occur because of mouth lesions which make eating as well as speaking difficult. Bedsores may easily follow due to the general poor condition of the skin and the difficulties in the care of it. Bronchopneumonia may develop because of the lack of movement in bed. These patients are very difficult to turn. Therefore, a Fowler's position is sometimes ordered to prevent the development of a chest condition. The excessive fluid formation is another factor pertaining to possible congestion in the lungs.

Sepsis, due to the formation of

Miss Fines is a student nurse at the Regina General Hospital.

toxins, may be one of the causes of death of patients with pemphigus.

SYMPTOMS

One of the first signs of pemphigus is the blister-like areas on the lips, mouth and eyelids, which, as the condition progresses, become covered with a thick crust. Gradually, as the disease progresses, bullous eruptions develop on almost all parts of the body. These burst, leaving raw, oozing areas. The exudate is at first a sterile, clear, serous fluid, but later it becomes infected and purulent.

"Nikoliski's sign" aids in the diagnosis of pemphigus. If a finger is pressed on the skin of the patient, the epidermis will be felt to slide on the underlying areas and may even be pushed off leaving a raw surface exposed.

Loss of weight and fatigue result. In the later stages, pyrexia may occur due to sepsis and toxins. Other late symptoms which are not peculiar to pemphigus are albuminuria, vomiting, and diarrhea.

On admission Mrs. M's T.P.R. was normal — 98^3 — 70 — 20. There was a gradual rise until the evening of the fifth day, when it reached 103° — — 98 — 20. From then on the chart showed fluctuating swings up and down between 103° and 98°. This was probably due to the secondary infection of the sores. On the morning of her death, the temperature rose to 106° (by axilla) but dropped to normal before expiration.

A post-mortem was held but, as expected, few pathological changes were found which could be directly related to the pemphigus. All medical texts agree that there are no specific lesions other than those on the skin and mucous membranes. There was congestion and hemorrhage in the lungs as well as some degree of lung collapse. The pathological report emphasized that these findings were not related to the skin disease but were co-incidental. A microscopic study of the skin lesions showed only evidence of acute inflammation with death of the tissues.

The abdominal cavity was free from adhesions and fluid. There was some congestion in the small intestine with more extensive areas in the colon. The liver was soft and paler than normal. No enlarged lymph nodes were found.

LABORATORY FINDINGS

The normal blood protein is 7-8 mgm. per 100 cc. serum. Mrs. M's blood protein gradually decreased to 4.1 mgm. per 100 cc. Normal blood protein is made up of two main components — albumin and globulin. There is twice as much albumin as globulin. However, with this patient the laboratory reports showed that the globulin level was higher than the albumin. It was deduced that she was losing more serum albumin than globulin in the oozing from the raw sores.

This patient's N.P.N. was never higher than 46-5 mgm. per 100 cc. blood. The normal N.P.N. is usually below 40 mgm. Since non-protein nitrogen is made up of waste material excreted by the kidneys, we see that this patient's kidneys were functioning quite well.

The blood reports did not show that the patient was anemic. The white blood count was not raised as it usually is in the presence of infection. However, the laboratory reports indicated that there were more eosinophils among her white blood count than is usually found. Such a condition is often found in allergy diseases, hence a possible inference that pemphigus may be due to an allergy.

When this patient was first admitted, there were no abnormal findings in her urine. Later, she developed blood cells and albumin. This shows that there was some kidney damage, because normally there are no blood cells or albumin in the urine.

TREATMENT AND NURSING CARE

The care of pemphigus patients is chiefly supportive and symptomatic treatment was used. Treatment consisted largely of good nursing care and bed rest. Because it has not been definitely established whether or not pemphigus is contagious, isolation technique was used.

Mrs. M's diet consisted of nourishing liquids and semi-soft foods off red to her at frequent intervals. This was a high vitamin, high caloric, concentrated diet to counteract the toxic effects of the disease. To begin with her appetite was fair and she was able to take nourishment reasonably well. But later, as more sores in her mouth developed and became larger, she was unable to swallow. Consequently nasal feedings, consisting of specially prepared, highly concentrated fluids, were commenced shortly before her death.

Sodium ortal or sodium amytal grs. III were given as a sedative. Morphine was also given to help her to rest and keep her from becoming depressed about her condition. Magnolax and cascara were given whenever necessary to relieve constipation. Later these were not necessary as the patient was having frequent, involuntary, liquid stools before her death.

Injection therapy: Blood transfusions of 500 cc. were given frequently to restore the blood and fluids lost through the oozing areas, and to bring the blood protein up to the normal level. They also counteracted secondary anemia and lowered resistance. Intravenouses of plasma protein were given for hypoproteinemia, i.e., when the plasma protein is below 4%. It is also useful to correct tissue edema. The blood and plasma transfusions succeeded in bringing the serum protein level up to over 6 mgm. per 100 cc. of blood. Also the serum albumin level became equal to the globulin level. To keep check on this, serum proteins and albumin-globulin ratios were done weekly.

Because the open areas were so painful a large part of the treatment consisted of trying to relieve the pain and make the patient more comfortable. Local treatment has no great effect on the eruptions, but medication is necessary to control the pain. A special ointment was ordered for the open areas but, due to difficulty in applying it, was not used much.

Potassium permanganate baths were given in the morning, alternating with starch baths in the evening. These helped to keep the skin dry and to counteract the fetid odor. Potassium permanganate baths were prepared by using one ounce of potassium permanganate crystals to a tub of warm water. The patient soaked in this solution for fifteen minutes and then the skin was allowed to dry.

To prepare starch baths, half a box of laundry starch was cooked until stiff and added to a tub of warm water. Considerable relief was obtained from these baths.

After the baths, and at frequent intervals during the day, talcum powder was sprinkled over all open areas of the body and absorbent cotton applied. This was done to keep the skin as dry as possible and to prevent loss of body serum.

Air-wicks were placed in the room to remove the foul odor as much as possible.

Because of the large areas of raw sores, the patient could not tolerate bed clothes. Therefore, a cradle was placed over her body. Also Mrs. M was extremely sensitive to cold and, in order to prevent her from becoming chilled, a baker was placed over her.

Besides this specific treatment it was the nurses' responsibility to do everything possible to cheer and comfort Mrs. M. She enjoyed visitors very much when she was allowed to have them.

In the later stages of the disease, the mucous and sanguinous discharge in her throat became very troublesome. Because of this her throat was suctioned frequently to give as much relief as possible.

Mrs. M had a fine spirit of determination which was much to be admired, and which helped to keep up her morale and cheerfulness through all her suffering. However, after a steady decline in health, she died three months after the first signs appeared. No definite decision was reached as to the actual cause of death. It may have been due to malnutrition.

Book Reviews

Rural Health and Medical Care, by Frederick D. Mott, M.D., and Milton I. Roemer, M.D. 608 pages. Published by McGraw-Hill Co. of Canada Ltd., 12 Richmond St. E., Toronto 1. 1948. Price $7.80.

Reviewed by Lyle Creelman, Field Director of Study, Canadian Public Health Association.

This book is timely for Canadian readers, even though the statistics and factual information relate to health and medical care in the United States. It is about the rural problem and, as in the United States, the vast surface of our country is predominantly rural. It is timely for two further reasons. First with the Federal Health Grants, health surveys are already underway in every province, and the future course of public health and medical care for Canada is now being plotted. As nurses, and a professional group vitally concerned, we should have as comprehensive a knowledge as possible of the subject. Secondly, Dr. Mott, the principal author of the book, is at present chairman of the Health Planning Commission in Saskatchewan. This province has had pre-paid hospital care for some time, and one demonstration rural area has, in addition, medical care. After reading Dr. Mott's book one realizes the background of information and experience which he has brought to his work in Canada, and we watch with all the more interest the development of the program in Saskatchewan.

We frequently hear it said, "People in the country are healthier." In Part II, Present-Day Levels and Trends of Rural Health, the authors show us that what appears on the surface is not actually true — "as measured by impairments and disorders, rural health is rather clearly poorer than urban." In this country, as well as in the United States, the majority of the professional health personnel are located in the urban areas. In the very short chapter on Nurses there is a paragraph which points up a fact which must be considered by all nurse educators. The paragraph reads: "The shortage of rural nurses is due partially to the poor opportunities for nurses' training in rural districts. Nursing schools in the rural sections are of smaller total capacity . . . and the great majority of nurses are educated in urban institutions. The young country girl going to the city for her training is naturally inclined to remain there, attracted by professional and social advantages. The relative infrequency of nursing schools in rural hospitals makes for further handicaps in rural nursing supply, simply because nursing service is not available from student nurses. The nurse who does obtain her training from a small rural hospital today is in general relatively poorly qualified in both the theory and practice of modern nursing. Yet, on graduation and employment in a rural hospital, she is saddled with greater responsibilities than the nurse in a city hospital, who is typically better trained and who has supervisors and resident physicians to fall back on for guidance."

We hope the authors are not implying that there should be more nursing students in rural hospitals so that there will be nursing service "available from student nurses," but at the same time the comment in the foot-note, "these institutions (urban) rarely have affiliations even with modern rural hospitals in which the student nurse might get a taste of rural nursing and rural life," is well made. Is there any hospital in Canada with such rural affiliations?

The final section of the book, The Road Ahead, points up the necessity for unified planning since, as is stated, "the delivery of a high quality of service to the rural patient is a product of interlocking endeavours all along the line." This is the kind of planning which we hope is going on in Canada today. "Rural Health and Medical Care" can serve as a very valuable guide to those most active in the planning. It is not a book which many nurses will want to buy or which many will want to read in detail. It is, however, one which should be made available in nursing libraries; one which some of us should study; and one of which all should at least read the introduction, and summary, of each of the eight parts.

Textbook of Chiropody, by Margaret J. McKenzie Swanson, B.Litt., F.Ch.S. 212 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1948. Illustrated. Price $5.00.

Reviewed by Atlanta S. Sollows, Reg. N., Dr. of Chiropody, Saint John, N.B.

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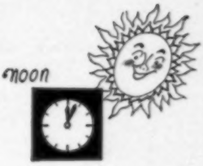

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purpose in giving — not only to the chiropody student but to all who read — an outstanding contribution to the subject of the "human foot." Her dealings with structure, normal and abnormal, posture and results of malposture, the hampering of normal development by careless or unwise footwear with its crippling dangers in the walk from the cradle to the grave, give this book a definite, universal value.

To those of the chiropody profession who have not had the extensive clinical experiences of the author, this book is especially recommended, though any medical library — including those in schools of nursing — would find the book an asset. It is profusely illustrated with advanced cases of prevalent foot diseases, vanity scars and minor deformities, both acquired and congenital. Their varied treatments are clearly defined and authentic. Constitutional diseases, such as Raynaud's disease, anemia, acrocyanosis, rheumatoid and osteo-arthritis, tuberculosis, diabetes, venereal, etc., all having effects upon the foot are given considerable stress. There is, however, assurance that no properly trained chiropodist will infringe upon, but rather will seek the co-operation of the medical practitioner.

On one point only does the reviewer disagree with the author, that being the use of steel plates and rigid metatarsal bars for arch correction. Elevation and support by all means, if necessary, but "flexibility" is nature's theme-song. Many years of orthopedic chiropody experience have shown the damaging results of rigid appliances excepting where there is paralysis or, for as long as one has to wear a cast or splint, especially in the aged, and where constitutional diseases are evident. Nevertheless, this textbook is excellent and will fill the need for which it was intended.

Everyday Problems of the School Child, by Agatha H. Bowley, Ph.D. 142 pages. Published by E. &. S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1948. Illustrated. Price $1.85. *Reviewed by Edith E. Hagar of Ardill, Sask.*

This little book presents the problems of school children from infancy to adolescence which are of concern to parents, teachers, and nurses. The author has reached her objective by describing the various problems such as impatience, misbehavior, poor concentration, lying, stealing, outbursts of temper, etc., and

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how they can be overcome by complete co-operation between the parents and teacher. She stresses that the teachers must know the mental ability of the children then adapt the teaching methods accordingly. For example—a child who lacks toys, play equipment, or companionship may be naughty and cause an upheaval in the home or school. When separated from his mother he may show signs of a stomach-ache or a feeling of sickness. He needs reassurance from his parents and the teacher because of his fear of school.

Delinquency, truancy, and sex education are carefully examined and explained by the author. She is convincing in her treatment of the subjects and has provided stimulating reading. She gives eleven photographs as illustrations of children at various activities.

Her writing possesses style and is presented in a clear and forceful manner. She has gone to fundamental sources for her information. The entire book is interesting, especially to those dealing with school children. I feel sure that they will find it valuable as a reference.

Nursing of Children, by Gladys Sellew, R.N., and collaborators. 486 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 6th Ed. 1948. Illustrated. Price $4.00.

Reviewed by D. June Stuart, Pediatric Supervisor, Royal Alexandra Hospital, Edmonton.

This textbook should prove not only very popular but most useful in any pediatric department or children's hospital as a handy, readily accessible, interesting reference book.

The authors have divided the book into two parts. Part I, Social Psychology of Childhood, not only includes a stimulating history of pediatric nursing and child welfare but a most enlightening and complete outline of the growth, development, and behavior of the child from birth up to and including adolescence. New thoughts and trends in the nursing and care of the ill and the well child are definitely emphasized. One need only note the "thought" of a "rocking-chair" in a modern hospital nursery, or the emphasis on the "care" of the poverty-stricken child, or the child of the "over-enthusiastic" parents, to show the wide and detailed coverage of child care included. Part II, Nursing of Children, is so compiled that one need only refer to the different "systems" to obtain complete data regarding abnormalities, diseases, etc., which is followed by a concise outline of the steps in their nursing care—

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the care being most modern, readily understood, and easily followed by any nurse. Then, to make it a more complete reference text for student nurses, each chapter concludes with good "thinking" questions and an up-to-date bibliography.

The authors complete the book with a number of useful menus for children and whole families as well. A little more emphasis could have been placed on the diet required in the care of the different diseases and conditions aforementioned throughout the book. The proper diet is most essential in the care of the ill or the growing child.

Health Center Buildings, by Harry E. Handley, M.D. 48 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1948. Illustrated. Price (in U.S.A.) 50 cents.

In this brochure, the seven buildings, which were constructed as a part of The Commonwealth Fund's program to house local health departments and their activities, are described in detail. The primary emphasis was to provide adequate accommodation which would combine "utility, fire resistance, low maintenance cost, and pleasing appearance." As these were all situated in two of the southern states, Tennessee and Mississippi, some of the features might not be so practical for our northern climate. However, the floor plans demonstrate the practicability of using every foot of space effectively. If such a public health building were contemplated in any Canadian community, these descriptions might be of service in planning the interior arrangement.

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Nursing Sisters' Association

At the annual meeting of the *Montreal Unit* the following officers were elected:

President, Evelyn Elliott; vice-president, Helen Hewton; secretary, Ethyle Percival; treasurer, Mrs. P. Bisaillon. Committees: Visiting, Mrs. Toller, Miss Kennedy-Reid; social, Misses Patterson (conv.), K. MacLeod, M. J. Youmans; special, Mrs. Mawhinney, Misses J. MacKay, M. Taylor.

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Alberta

The following are staff changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: *Gladys Carveth* (Royal Alexandra Hospital, Edmonton), Whitemud Creek; *Wilma E. Doyle* (Toronto General Hospital; University of Alta. public health course; advanced course in practical obstetrics), Maloy; *Ruth I. Edeen* (Calgary General Hospital), Foremost.

Transfers: *Ethel Jones* from Sunnynook to Bow Island; *Nina Renwick* from Bonanza to Hemaruka.

Leaves of Absence: *A. L. Lewis* from Bow Island; *Alice Murphy* from Lindale.

Resignations: *June Polley* from Foremost; *Mrs. C. Hudson* from Spirit River; *Gladys G. Hutchings* from Wheatland health unit to be married.

Canadian Red Cross

The following are staff changes with the New Brunswick Division:

Appointments: *Agnes Spilman* (Victoria Public Hospital, Fredericton), *Carolyn McAloon* (St. Joseph's Hospital, Saint John), and *Doris Tomilson* (Montreal General Hospital) to Stanley Memorial Hospital; *I. M. Clarke* (Providence Hospital, Moose Jaw), *Ruth Hawthorne* (Fisher Memorial Hospital, Woodstock), *Anne Gardiner* (St. J.H., Saint John), and *Doris McGrand* (St. J.H., Saint John) to Queens-Sunbury-West Memorial Hospital at Fredericton Junction.

Ontario

The following are staff changes with the Ontario Public Health Nursing Service:

Appointments: *Lyle Fauteux* (Toronto General Hospital and University of Toronto cert. course), formerly with Prescott and Russell health unit, to Hamilton Board of Health; *Jean Hollingsworth* (T.G.H. and U. of T. cert. course), Oshawa Board of Health; *Mary Zeagman* (St. Michael's Hosp., Toronto, and U. of T. cert. course), St. Catharines-Lincoln health unit.

Resignation: *Susan Scales* (Guelph Gen. Hosp. and U. of W. Ont. cert. course) from Lennox and Addington health unit.

Victorian Order of Nurses

The following are staff changes with the Victorian Order of Nurses for Canada:

Appointments — Brantford: *Mary L.*

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Re-appointments — Hamilton: *Dorothy J. Nicol*. Liverpool: Nellie Beaton. Montreal: *Elizabeth Appleyard* and *Louisa Pile*. Sackville: *Gwendolyn Angus*.

Transfers — *Ruth Franklin* from Vancouver to Calgary; *Beryle Hawley* from Montreal to Port Colborne; *Mary Sehl* from Kitchener to Waterloo.

Leaves of Absence — *Hattie Empey* from Hamilton; *Annie Proudfoot* from Montreal.

Resignations from — Calgary: *Vera G. O'Dell* to take up other work. Cornwall: *Helen Dwyer* to take up other work. Guelph: *Kay (Smythe) Cunningham*. Liverpool: *Gladys (Hergett) Haack*. Moncton: *Julia Gabris*. Montreal: *Jacqueline Blanchard* to take up other work, *Craty Carageorgiou*, *Edith S. Russel*, *Gladys Van* (retired), and *June A. Yearwood* to take up other work. Ottawa: *Mary Moxley* (retired) and *Edith Stevenson* to serve with the Department of National Health and Welfare. Peterborough: *Marion Webster* to return to psychiatric nursing.

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La Salle, P.Q.

Sudbury: *Arlette Silverthorn*. Timmins: *Mabel Bourne* to take a public health course. Toronto: *Janet Britnell, Fern Campbell, Violet Dick* to take up other work, *Doris H. Fowler* to take up other work, *Frances Houlton* to join the Department of Health, *Madeline Pierce, Marguerite Stinson* to take up other work, and *Marjorie Weichel* to join the U.S.A. Lutheran Child Welfare Association. Vancouver: *Margaret Goodwin, Sylvia Junek, Margaret Ross* to be married, and *Phyllis Soanes*. Waterloo: *Elizabeth* (*Skinner*) *Ferguson*. Winnipeg: *Alma Ivey*.

Appointments— Halifax: *Kathleen Fultz* (Halifax Infirmary). Kitchener: *Jean Haynes* (Victoria Hosp., London). Ottawa: *Jane MacIntyre, B.Sc.* (Toronto Gen. Hosp. and McGill University p.h.n. course). Owen Sound: *Winnifred James* (Victoria Hosp., London). Peterborough: *Muriel Laturney* (Kingston Gen. Hosp. and University of Toronto p.h.n. course). Toronto: *Joyce Bagshaw, Mary E. MacLean,* and *Sybil Steele* (all U. of T. School of Nursing). York Township, Ont.: *Ruth Edwards* (T.G.H.).

Re-appointments— Brantford: *Dorothy Knight* as nurse-in-charge. Toronto: *Ethel Grindley*. Vancouver: *Sylvia Junek*. Victoria: *Winnifred Tredaway*.

Transfers— *Annie Fentiman* from Burnaby to West Vancouver; *Dorothy Fullerton* from Saint John to Trenton, Ont., as nurse-in-charge; *Claire Gauthier* from Winnipeg to Ste. Anne de Bellevue; *Elizabeth Hayden* from Carleton Place to Vancouver; *Helen Kennedy* from Ste. Anne de Bellevue to Rouyn-Noranda; *Liv-Ellen Lockeberg* from Timmins to Porcupine as nurse-in-charge; *Nora Main* from Surrey to Vancouver; *Katherine McLellan* from Halifax to Cobalt, Ont., as nurse-in-charge; *Isabel Neilson* from Victoria to Carleton Place, Ont., as nurse-in-charge; *Ellen Pocock* from Porcupine to Gravenhurst as nurse-in-charge; *Catherine Ross* from Vancouver to Richmond, B.C., as nurse-in-charge; *Evelyn Stoskopf* from Kitchener to Galt; *Isla Tuck* from Elphinstone to Surrey; *Margaret Whitecross* from West Vancouver to Burnaby.

Leaves of Absence— *Muriel Morgan* from Lincoln County; *Joan Simons* from Sudbury.

Resignations— *Frances Bell* from Ottawa, *Jacqueline Cadieux* from Rouyn-Noranda, *Arminal Hay* from Trenton, *Dorothy King* from Brantford, and *Mary F. Zeagman* from Toronto, all to take other work; *Nancy Bolton* from Surrey, *Joan* (*Bayliffe*) *Brown* from Brantford, *Laurie Fages* from Brockville — marriage; *Bette Bradford* from Brantford, *Virginia Kendall* from York Township, *Mary Wardman* from Windsor, Ont., and *Margaret Wishart* from Toronto, all for home responsibilities.

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REGISTRATION OF NURSES
Province of Ontario
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EXAMINATION ANNOUNCEMENT
•
An examination for the Registration of Nurses in the Province of Ontario will be held on **May 18, 19 and 20.**

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

The Director,
Division of Nurses Registration
Parliament Buildings, Toronto 2

News Notes

ALBERTA

EDMONTON:

V. Chapman was in the chair at a recent meeting of Edmonton District 7. It was decided that, in order to obtain a better attendance at district meetings, individual notification cards would be sent to all nurses in the district. The film "Mother and Child" was shown to the members and was found to be enjoyable as well as educational.

Royal Alexandra Hospital:

Mrs. D. Ferrier presided at a recent meeting of the alumnae association when plans were made for a bridge and the annual banquet. Ida Johnson and V. Chapman were named as delegates to the I.C.N. Conference to be held in Stockholm in June. It was announced that a bazaar is planned for the fall with Mrs. N. Richardson as convener.

A scholarship of $250 is to be awarded and information regarding this may be obtained from June Stuart at the hospital.

LETHBRIDGE:

At a recent meeting of Lethbridge District 8 the following officers were elected: President, A. Short; vice-presidents, Sr. M. Peters, B. Hoyt; secretary, L. Watson; treasurer, I. Schmaltz; program convener, M. Mills; social convener, A. Hofer; representative to press and *The Canadian Nurse*, D. Watson.

At a later meeting the senior class of Galt Hospital School of Nursing were guests of the chapter when Miss Hoyt presided. Miss Mills introduced Dr. G. S. Gray who has returned after three years' service in Burma with the Canadian Army. His illustrated lecture of Burma as he saw it was much enjoyed.

BRITISH COLUMBIA

ABBOTSFORD:

Twenty members were present at a recent meeting of the Matsqui-Sumas-Abbotsford Chapter, when the president, Sheila Towlan, was in the chair. After the annual report was read by the secretary, Mrs. Fern Lillies, Dorothy Irwin, public health nurse, gave an interesting outline of her work.

CHILLIWACK:

Mrs. Grayce Roberts, the president, was in the chair at a recent meeting of Chilliwack Chapter. The nominations for the provincial officers were forwarded. Mmes McKay, G. Wilson, and Miss Henderson were appointed as purchasing conveners and it was decided to buy a dozen straight-back chairs for the nurses' home. Plans were made for a window display of "pins" from the various training schools. A donation was sent towards the expenses of delegates from the devastated areas in Europe to the I.C.N. meetings.

A social hour followed when entertainment was provided by a local children's dancing class and community singing.

KAMLOOPS-TRANQUILLE:

A successful tea, which netted a considerable sum, was sponsored by the Kamloops-Tranquille Chapter, in aid of their Scholarship Fund and other projects. The raffling of a hand-knit sweater and gift certificates totalled $238. Homecooking, White Elephant stall, and tea room added $133.80 to the coffers. The convener for this event was O. Garrood.

The March meeting was held in Tranquille when plans were made for the allotment of funds from the tea. The Red Cross received $25 and $200 was transferred to the Scholarship Fund. Forty-five dollars was donated to the Unitarian Service Committee which enables the chapter to "adopt" a European child, clothe and feed him for three months.

Moira Foster, of the Tranquille staff, closed the meeting with a helpful and informative chat on "Nursing Care of the Thoracoplastic Patient."

PRINCE RUPERT:

Edna Dobbie was elected president of Prince Rupert Chapter at a recent meeting. The vice-president is Margaret Steeves; Barbara Johnson is secretary, while Phyllis Mooney will serve as treasurer.

A discussion was held regarding registration and the proposed revisions in personnel practices. Plans were made for the raising of funds for the chapter to include a dance.

Vancouver General Hospital:

This year marks the fiftieth since the Training School was founded. To celebrate the anniversary, the alumnae association is planning a reunion for May. Mrs. G. Wyness is general convener with her assistant, Mrs. M. W. Bakkan. The program, which should prove interesting with a large attendance at the functions, is as follows:

May 17—Morning: Registration and coffee party. Afternoon: Sightseeing. Evening: Attendance at graduation exercises. Margaret E. Kerr, editor of *The Canadian Nurse* and a V.G.H. graduate, will give the convocation address.

May 18—Afternoon: Tour of hospital and tea. Evening: Alumnae banquet for graduating class.

May 19—Afternoon: Class events. Evening: Alumnae party and ball.

MANITOBA

BRANDON:

C. Wedderburn, the president, was in the chair at a recent meeting of the Association of Graduate Nurses when Mrs. S. J. S. Peirce reported sending several more food parcels to a children's hospital in England. Plans were made for several future functions.

Nan Crighton's group was in charge of the program and she introduced Dr. Stuart Schultz as guest speaker. He revealed some interesting factors in a well chosen study—

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For further information apply to:

Superintendent of Nurses,
Mountain Sanatorium,
Hamilton, Ontario.

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Registered Nurses without public health preparation will be considered for temporary employment.

Scholarships are offered to assist nurses to take public health courses.

Apply to:

Christine Livingston
Chief Superintendent
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Ottawa.

"Personality." The speaker was thanked by Lois Booth.

A social hour followed when a draw was made, with Mrs. D. Bonk winner of the Scholarship Committee prize.

NEW BRUNSWICK

SAINT JOHN:

The Saint John Chapter recently held a regular meeting at the Tuberculosis Hospital when the staff nurses were hostesses at a social evening which followed the business session.

General Hospital:

The 1942 class of the School for Nurses recently held a reunion with K. Bell as hostess. Bridge and a social get-together were enjoyed. Those present included: J. McAllister, L. DeBly, M. Craig, L. (Richardson) Stirling, A. (Lewis) Merritt, C. Henderson, I. Irvine, P. (Smith) Ross.

St. Joseph's Hospital:

Mr. Harry Daley was the guest speaker at a regular meeting of the alumnae association when his topic was "Credit Unions." It was reported that a food parcel had been packed for a needy family in Britain. Marie Wallace, the president, was in the chair.

Nineteen junior nurses were recently "capped" with the customary ceremony. The entrance march was played by A. Peterson, and a choral number was sung by the seniors and intermediates. R. Hurley was accompanist.

Rev. Sr. Helen Marie, director of nurses, addressed the class following which the capping ceremony was carried out. A welcome was extended by Rev. Sr. M. Veronica, administrator of the hospital, and Rev. Sr. M. Bernard, representing Rev. Mother M. Joan, head of the Sisters of Charity of the Immaculate Conception in Canada, conveyed greetings.

Members of the junior class rendered "Santa Lucia," accompanied by F. Morrison. Rev. Arthur J. Gilbert, hospital chaplain, led in the recitation of the Nightingale Pledge.

ST. STEPHEN:

The home of Mrs. H. White was the scene of a recent meeting of St. Stephen Chapter when C. Dowling, the president, was in the chair. It was reported that a box for the British nurses had been forwarded and another was to be sent in the near future. An article entitled "Night Watch" was read from the February *Journal*. This was of special interest to the members as the author, B. Banfill, was at one time night supervisor at the Chipman Memorial.

At a later meeting a talk was given by Dr. H. S. Everett on "Surface-Biopsy Cytology." He explained the Papinacalou, New York, and the Dr. J. E. Ayre method (also known as the McGill method) for early diagnosis of cervical cancer. This was followed by a film, showing tissue scrapings under microscope, and interpreting the changes indicating cancer cells. The film was provided through the courtesy of Dr. Ayre.

Hilda Bartsch was welcomed as a member of the chapter. She succeeds Reta Follis as superintendent of Chipman Memorial Hospital. Miss Follis, who resigned, is now living in Georgia.

ONTARIO

DISTRICTS 2 AND 3

BRANTFORD:

Ninety-six members were present at the district annual meeting when the chairman, Margaret Grieve, presided. Following the business session, Dr. McDougal, of Brant Sanatorium, gave an address on "The Treatment of Tuberculosis." Dr. Paul Moses, urologist from the Brantford Clinic, gave a comprehensive outline of the work being carried on in this field of medicine. Bonnie Mitten, student nurse, delighted everyone with two vocal solos.

A sumptuous dinner was served by the General Hospital Alumnae Association when Mrs. A. Graham, of Hamilton, who is an expert on floral arrangements, talked on "Styles in Flowers." Draws were made for the beautiful bouquets, corsages, and floral novelties which the speaker had for demonstration.

In January, the Recruitment Committee of the district invited the hospital superintendents and chairmen of the hospital alumni to a high tea at the General Hospital. The purpose of the meeting was to discuss ways and means to interest young girls in the nursing profession. An award has been offered to the hospital presenting the best recruitment program, judges to be selected by the executive. Bursaries from the various service clubs in two localities are being offered to high school students who wish to go in training.

Four members from the district will attend the I.C.N. meetings in Sweden.

OWEN SOUND:

A scholarship of $300 will be given to any member of the Owen Sound Nurses' Alumnae Association who wishes to take a postgraduate course in teaching and supervision. All those interested are asked to write to the alumnae secretary at Box 605, Owen Sound.

DISTRICT 4

ST. CATHARINES:

Bernice Lousley, chairman of Niagara Chapter, presided at a recent meeting when Dr. C. G. Shaver, who was introduced by A. Oram, past chairman of the district, was the guest speaker. His address on "Tuberculin Vaccine" and concerning the new Niagara Peninsula mobile unit proved most interesting. Movies of this unit were shown, the operations being explained in detail. A social hour was enjoyed when a buffet tea was served by M. McCort of the Peninsula Sanatorium.

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- **The Woman's Missionary Society of The United Church of Canada** is in urgent need of nurses for work in *11 hospitals in Canada.*

- In overseas hospitals in *India, Angola (Africa), West and South China,* we need nurses with special skill in Administration, Instructing, and Public Health. Interesting information on these medical and nursing activities may be received from **Miss Leslie Bowman, Room 530, Wesley Bldgs., Toronto 2B, Ontario.**

PRINCIPLES OF PEDIATRICS

By Cecilia M. Knox, Boston City Hospital. This outstanding book is concerned with the child in both health and disease, with its total behaviour and development — physical, mental, social and emotional. 63 illustrations, 527 pages, second edition revised, 1947. $4.00.

FOOD IN HEALTH AND DISEASE

By Katherine Mitchell and Genevieve Gormican North. A book of the first importance for its diets, menus and recipes. For this latest printing the section dealing with diet in disease has been enlarged. 57 illustrations, 616 pages, 17th printing, fourth edition, 1948. $4.00.

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DISTRICT 8

CORNWALL:

At a recent meeting of the General Hospital Alumnae Association, held at the home of Ethel Allen, plans were made for a food sale, the proceeds of which will go towards the endowment of a room in the new wing of the hospital.

OTTAWA:

The Ontario Conference of the Catholic Hospital Association of the U.S. and Canada sponsored an institute on Nursing and Nursing Education at the University of Ottawa, March 21-25. An interesting program covered every phase of nursing and nurse education.

Margaret Foley, director of nursing education for the Catholic Schools of Nursing in the U.S. and Canada, gave able assistance from her wide knowledge and experience. Several field trips included a tour of the Parliament Buildings and a visit to the Mint. The delegates expressed great satisfaction in the profitable five days which should prove an inspiration in the busy days ahead.

DISTRICT 9

SUDBURY:

Returned to office as chairman of District 9 during the 25th annual meeting, Mrs. Isabel Gleason, public health nurse of Haileybury, will direct the affairs of the district for the coming year. Others elected included: Vice-chairmen, Lois Smith, Sault Ste. Marie, and E. Houston, Kirkland Lake; secretary-treasurer, Mrs. J. McLean, New Liskeard.

An official welcome to the city was extended at the morning session by Mayor W. S. Beaton. P. Brunelle, vice-president, Sudbury Chapter, extended a welcome on behalf of the hostess group. Mrs. McLean reported on the 1948 annual meeting. Other reports included: Public health, Clare Douglas; hospital and school of nursing, Rev. Sr. Camillus; membership, Lois Kelly; *The Canadian Nurse*, Muriel Rice; finance, Mrs. M. Stewart; general nursing, G. Johnston. Delegates from the various chapters also discussed their activities.

A luncheon was given by the alumnae of St. Joseph's Hospital, the convener being G. O'Leary. Mrs. Gleason was in charge of the afternoon session when Nellie Keillor, president, Sudbury Arts and Crafts Club, spoke briefly. Mrs. H. J. Cullen, of Frood, was also a guest speaker and took as her theme "World Friendship." Mrs. Stewart convened a meeting of the finance committee, attended by chapter delegates.

Mary Millman, a faculty member of the University of Toronto School of Nursing, was speaker at the supper. An executive meeting followed this gathering.

Arrangements for the successful meeting were in charge of Mrs. F. Sheridan.

Members of the Sudbury Chapter executive include: President, I. Penman; vice-president, P. Brunelle; secretary-treasurer, B. Young. Committee conveners: General nursing, W.

MacFadden; hospital and school of nursing, Sr. St. Philip: public health, W. Carter.

PRINCE EDWARD ISLAND

The P.E.I. Registered Nurses' Act passed the Provincial Legislature without revision, but only after a stormy passage due to a misinterpretation regarding "the practical nurse." The drafting of this new act was largely the work of E. Frances Upton and Eileen Flanagan, of Montreal, who came to the province last November at the request of the nursing sub-committee of the Provincial Health Planning Commission. At this time Miss Upton made a survey of the three schools of nursing and two special hospitals—the Provincial Sanatorium and Falconwood.

Mona Wilson, public health nursing director, Department of Health and Welfare, attended the Dominion-Provincial Conference on Health Education and Nutrition in Ottawa. Ruth Ross is doing a year's post-graduate work in advanced public health nursing at the University of Michigan. Mrs. John C. Cameron, of Tignish, and Bessie Beer, of Charlottetown, are taking a ten-week refresher course with the Visiting Nurses' Association of Hartford, Conn. These nurses are all with the public health nursing division.

Lois Brady is taking public health at McGill School for Graduate Nurses. Margaret Doyle is also at McGill enrolled for teaching and supervision.

QUEBEC

MONTREAL:

General Hospital:

Helen M. Nicholson, assistant director, McGill School of Physiotherapy, was the speaker at a recent alumnae meeting when her subject was "Physiotherapy as It Applies to the Field of Nursing, both Preventive and Curative." The members found this lecture both interesting and instructive.

Ida G. Latham, a Nightingale International Foundation Scholarship student from Great Britain, spent some time recently as a guest of the school. Miss Latham is chief administrative nurse of the O.R. department of the London Hospital.

Royal Victoria Hospital:

Elizabeth Graham, now on the supervisory staff of the Winnipeg General Hospital, is anticipating taking charge of the eye, ear, nose and throat ward. Alice Fraser is a member of the O.R. staff at Baker Memorial Hospital, New York.

Helen Schurman, superintendent of nurses, Victoria Public Hospital, Fredericton, recently spent a day at the school observing in the teaching department and procedures on the wards. Mary Prescott has returned to her home in Acacia Grove, Starr's Point, N.S., after spending several months in Montreal.

QUEBEC CITY:

At a recent meeting of Jeffery Hale's

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Hospital Alumnae Association, Dr. W. Delaney gave an interesting talk on "The Newer Drugs."

Cora Sellers is now superintendent of All Saints' Hospital, Springhill, N.S. E. Ramsay is on the staff of Belleville General Hospital, Ont.

SASKATCHEWAN

With the assistance of the Federal Grant it has been possible again to place public health nurses on the staffs of the provincial normal schools. Dorothy M. Hopkins is at Saskatoon and Mrs. H. A. Fletcher is in Moose Jaw. I. M. A. Mercer, P. Robinson, and Mrs. B. Cumberland have been assigned to Saskatoon district, North Battleford, and Weyburn regions respectively. G. Aylsworth has reported for duty at Swift Current. M. Floyd has transferred from Weyburn to the provincial Division of Public Health Nursing.

HUMBOLDT:

The capping ceremony of eleven happy students recently took place at St. Elizabeth's Hospital when the ceremony was followed by a short program and lunch.

Partial remodelling of the maternity ward has been completed, including the installation of new equipment.

REGINA:

General Hospital:

At a recent meeting of the alumnae association, Ethel James, S.R.N.A. president, was the guest speaker when her topic was "Current Events in Nursing." The alumnae was glad to welcome other graduates on the hospital staff to hear the guest speaker.

One of the alumnae's new projects includes an Alumnae Book. This will contain the names of all graduates from the commencement of the school, their married names, present address, and year of graduation. L. Garland is convening this committee and each graduate is invited to write concerning her opinion of this project. A bazaar and tea are also planned.

Grey Nuns' Hospital:

Sr. D. Lefebvre, of Montreal, was a visitor recently and spoke to the graduate staff. Isabel Brown and Joyce Sanderson are new additions to the staff.

SASKATOON:

Dr. D. M. Baltzan was guest speaker at a meeting of Saskatoon Chapter when his topic was "Psychosomatic Medicine."

City Health Department:

Recent additions to the staff include: M. Horbay, S. Skolrood, F. Wensley, B. Kendry, R. Dulmage, F. McKenzie.

City Hospital:

Dr. Binning, chief medical officer of Saskatoon Public Schools, was guest speaker at a recent alumnae meeting. He gave an informative, illustrated address, showing the effects that emotional disturbances have on the physical and mental growth and development of a child.

St. Paul's Hospital:

The nursing staff was privileged to hear a lecture by Sr. D. Lefebvre who is nursing education director of Institut Marguerite d'Youville, Montreal.

Regret is expressed at the departure of Rev. Mother Mann, provincial superior, who is leaving the province. A hearty welcome is extended to Rev. Mother Vincent who succeeds her. Mother Vincent was at one time superior at St. Paul's.

His Excellency, Bishop Pocock, was guest speaker at a sodality meeting when all students were in attendance. Dr. R. H. MacDonald recently closed a series of lectures to the nurses when he spoke on "Staff Education."

Saskatoon Sanatorium:

Iris Gordon has resigned to take a position in the O.R. of Victoria Hospital, Prince Albert. New staff members include: Jean Davey, Ellen Epp, and Katherine Dyck.

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Science Instructor for Fall Term in 150-bed hospital. 60 students. 44-hr. wk. **Obstetrical Supervisor.** Advanced course in Obstetrical Nursing. Immediate opening. Apply, stating qualifications, experience, salary expected, Supt. of Nurses, Moncton Hospital, Moncton, N.B.

Obstetrical Supervisor to take charge of 50-bed Maternity Dept. & teaching Obstetrical Nursing. Post-graduate course as well as experience in Obstetrics preferred. Apply, stating qualifications, Director of Nursing, General Hospital, Saint John, N.B.

Supervisor for Children's Ward. Post-graduate course in Pediatrics necessary. Must be eligible for registration in B.C. 6-day wk. 1 mo. vacation yearly. Excellent salary. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

Registered Nurses for General Staff to relieve for Summer vacations, commencing June 1. Possible permanent positions. Gross salary: $150 per mo. $30 deducted for full maintenance. Must be eligible for registration in B.C. Apply Matron, Queen Victoria Hospital, Revelstoke. B.C.

Nursing Arts Instructor & Science Instructor to join Teaching Staff of 450-bed hospital. No. of students, 150. Positions open June 1. Apply, stating qualifications, Principal, School of Nursing, General Hospital, Saint John, N.B.

Night Supervisor, Asst. Night Supervisor, Supervisor for Surgical Ward, General Duty Nurses—all required at once. Apply, stating qualifications, Miss O. Waterman, Supt. of Nurses, McKellar General Hospital, Fort William, Ont.

Floor Supervisor & Registered Nurses for General Duty immediately. 8-hr. duty, 6-day wk. Apply Acting Supt. of Nurses, General Hospital, Woodstock, Ont.

General Duty Nurses for 80-bed General Hospital. Salary: $115 per mo. (including pay for O.R. call & bonus) plus maintenance. Increase at end of 6 mos. to $120 & at end of 1 yr. to $125. 8-hr. day, 6-day wk. 2 wks. holiday with pay (3 wks. given at end of 2nd yr.). Allowance for sick leave, hospitalization, statutory holidays. Additional $5.00 per mo. paid for 3:30 shift. Apply, stating qualifications & date available, Supt., Norfolk General Hospital, Simcoe, Ont.

Graduate Floor Duty Nurses. Salary: $120-$130 per mo. plus full maintenance. 8-hr. day, 6-day wk. Free hospitalization & medical & nursing care if ill, & laundry. Vacation with pay at end of 1 yr. service. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.

Graduate Nurses for General Duty. Salary: $110 per mo. & $120 per mo. night term, both with full maintenance. Apply Supt., General Hospital, Kenora, Ont.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan, 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

Vancouver General Hospital requires: **Asst. Night Supervisor.** Salary: $227 gross, including current Cost of Living Bonus. **General Staff Nurses** for *vacation relief.* Salary: $172 gross, including current Cost of Living Bonus. Extra premium for evening or night duty. Registration in British Columbia required. For further information apply Director of Nursing, General Hospital, Vancouver, B.C.

Nursing Arts Instructor for 300-bed hospital. Gross salary: $190. Duties to commence Aug. 1. 8-hr. day, 6-day wk. 1 mo. vacation annually. Apply Supt. of Nurses, McKellar Hospital, Fort William, Ont.

Operating-Room Supervisor & Nursing Arts Instructor. Immediate opening. Good location. State Capitol with many civic advantages. Salary open. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

Operating-Room Supervisor immediately. Salary: $170. 44-hr. wk. Must be eligible for B.C. registration. Apply Supt. of Nurses, Children's Hospital, 250 West 59th Ave., Vancouver, B.C.

Head Nurses, General Staff Nurses. Liberal salaries. Excellent living conditions with recreational facilities. 1 mo. annual vacation. 5-day wk. Apply Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, Que.

Public Health Nurses for generalized Public Health work in County Health Unit. Halfway between Ottawa & Montreal. Salary: $1,900 to start. Cars provided. Must be bilingual (French & English). Apply, stating age, experience, etc., Director, Prescott & Russell Health Unit, 33 Main St. W., Hawkesbury, Ont.

Graduate Dietitian at Ontario Hospitals in Brockville, Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum, plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock & Toronto Psychiatric Hospital. Initial salary: $1,840 per annum, plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

General Staff Nurses, 44-hr. wk. Starting gross salary: $155. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for 350-bed Tuberculosis Hospital. Blue Cross hospitalization plan. For further information apply Miss C. L. Bartsch, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

General Duty Nurses. Salary: $130 for first 6 mos. & $135 after 6 mos. service plus maintenance. 8-hr. day, 6-day wk. 2 wks. holidays after 1 yr. service plus statutory holidays. Apply Supt. of Nurses, Municipal Hospital, Brooks, Alta.

• WANTED •

by

CANADIAN RED CROSS SOCIETY

- ***Blood Transfusion Service*** requires Supervisory and Staff Nurses to be stationed in New Brunswick, with headquarters in Saint John.
- ***Registered Nurses for Outpost Service*** in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- ***Commensurate salaries*** for experience and qualifications. Transportation arranged under certain circumstances.

For further particulars apply:

NATIONAL DIRECTOR, NURSING SERVICES, CANADIAN RED CROSS SOCIETY,
95 WELLESLEY ST., TORONTO 5, ONT.

• WANTED •

at

SHERBROOKE HOSPITAL, SHERBROOKE, QUEBEC

- **ASSISTANT SUPERINTENDENT OF NURSES**
- **NIGHT SUPERVISOR**
- **SCIENCE INSTRUCTOR**

The present hospital is in process of reorganization in preparation for transfer to new hospital (capacity, 162 beds) and new Nurses' Residence now under construction.

To prepare for the larger unit the School of Nursing requires added teaching and supervisory staff.

Apply, stating qualifications, experience & salary expected, to **Supt. of Nurses, Sherbrooke Hospital, Sherbrooke, Que.**

Public Health Nurses (2). Duties to commence this Summer. Area to be served includes town of about 4,000 pop. where the nurses will be expected to live & where Health Unit maintains branch office. *Conditions of service:* Present minimum salary, $1,800 per annum; suitable adjustments made for experience. 4 wks. vacation. Cumulative sick leave. Admission to pension scheme after 1 yr. service (or immediately on employment if applicant has transferable pension rights). Car allowance, $645 and, if necessary, interest free loan for car purchase. Apply Supervisor of Nurses, Elgin-St. Thomas Health Unit, City Hall, St. Thomas, Ont.

Supervisor of Nursing for 165-bed, 45-bassinet hospital in Chicago suburb, fully approved. Post-graduate experience in Teaching or Supervision essential. To organize & conduct Educational Program for all-graduate staff; also to act as Asst. to Director of Nursing. 44-hr. wk. Salary: $250 & full maintenance. Apply Director of Nursing, MacNeal Memorial Hospital, 3249 S. Oak Park Ave., Berwyn, Illinois.

Classroom Instructor for 75-bed hospital. Apply, stating age, experience, salary expected, Supt. of Nurses, Ross Memorial Hospital, Lindsay, Ont.

Registered Nurses for General Duty. Salary: $120 per mo. plus full maintenance. Apply Director of Nursing, County General Hospital, Welland, Ont.

General Duty Nurses for 75-bed hospital. Salary: $155 gross. 8-hr. duty, 6-day wk. 28 days' vacation. Statutory holidays. Comfortable living quarters—golfing, fishing, swimming, etc. Apply St. Joseph's Hospital, Comox, V.I., B.C.

General Duty Nurses immediately for 30-bed hospital, situated in Southern Interior of B.C. Gross salary: $150, less $20 maintenance. 8-hr. duty. 4 wks. vacation with pay after 1 yr. service. 9 statutory holidays. Generous recreational facilities. Close to U.S. border. Apply Mr. A. Rutherford, Sec.-Mgr., Community Hospital, Grand Forks, B.C.

Graduate Nurses for General Staff in modern 110-bed hospital in Fraser Valley. Commencing salary: $150 gross. Increments in accordance with R.N.A.B.C. salary schedule. 44-hr. wk, 8-hr. day. 28 days' holiday plus 10 statutory holidays. 65 miles from Vancouver. Good bus service. Apply, stating experience, etc., Nursing Supt., General Hospital, Chilliwack, B.C.

Supt. of Nurses for Fall Term for 140-bed General Hospital with Training School of 50 students. Apply, stating qualifications, experience, salary expected, Supt., Aberdeen Hospital, New Glasgow, N.S.

Registered Nurses for General Staff in 20-bed hospital. Salary: $142.50 per mo. plus laundry & $15 bonus payable every 3 mos. 8-hr. day. Cumulative sick leave allowance, hospitalization plan. Permanent hospital under construction. Apply Supt., Oakville & District Temporary Hospital, Oakville, Ont.

Night Supervisor for 250-bed Tuberculosis Sanatorium. Salary: $190 gross, less $30 for full maintenance. 3 wks. annual vacation. Sick leave, hospitalization, pension plan, group insurance. Salary increase after 6 mos. Transportation refunded after 6 mos. satisfactory service. Apply Supt. of Nurses, Fort William Sanatorium, Fort William, Ont.

Resident Nurse for King's Hall, Compton, Que. Boarding school for about 130 girls, 13 miles from Sherbrooke & 100 from Montreal. Open Sept. 13. Salary: $1,200 for school yr. plus full maintenance. 4 wks. holiday at Christmas & 2 at Easter. School closes around middle of June. Apply Miss Adelaide Gillard.

Matron for 15-bed hospital. Salary: $160 plus maintenance. For further particulars apply Sec.-Treas., Municipal Hospital, Myrnam, Alta.